

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 1c File # 6-16-58 et

06930

6967

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 16 7877 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington		d. STREET ADDRESS 3850 Tunlaw Road, N.W.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First Samuel	Middle Edwin	Lost Atkinson	4. DATE OF DEATH June 10 1958	Month June	Day 10	Year 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 3 November 1885	9. AGE (In years last birthday) 72 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	Hours 0	Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Apartment Manager				10b. KIND OF BUSINESS OR INDUSTRY Apartment Management	11. BIRTHPLACE (State or foreign country) New York				
12. CITIZEN OF WHAT COUNTRY? U.S.A.									
13. FATHER'S NAME Samuel Edward Atkinson				14. MOTHER'S MAIDEN NAME Julia Erickson					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. 285-14-3154		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) UREMIA DUE TO 2043 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) ACUTE LYMPHOCYTIC LEUKEMIA 6 months. DUE TO (c)									INTERVAL BETWEEN ONSET AND DEATH one week
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) PSEUDOMONAS SEPTICEMIA									19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from March 24, 1958 , to June 10, 1958 , that I last saw the deceased alive on June 10, 1958 , and that death occurred at 2:00a.m. from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center The National Institutes of Health Bethesda 14, Maryland									DATE SIGNED 6/10/58
ACTUAL SIGNATURE <i>Richard K. Shaw</i>		M.D.							
PHYSICIAN'S NAME (Type) Richard K. Shaw, M. D.									
22a. BURIAL, CREMATION, BURIAL (Specify) Burial		22b. DATE THEREOF 6/12/58		22c. NAME OF CEMETERY OR CREMATORIUM Fort Lincoln Cemetery		22d. LOCATION (City, town, or county) Prince Georges County, Md.			
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co. 2901		ADDRESS Wash. D.C. 14th St., N.W.		24a. REC'D BY REGISTRAR JUN 11 '58			24b. REGISTRAR'S SIGNATURE <i>Albert J. Schuch</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be signed by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06932

6936

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>District of Columbia</i>		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park, Md</i>		c. LENGTH OF STAY IN Tb <i>5 days</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Washington, DC</i>		d. STREET ADDRESS <i>706 Nicholson St NW</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Washington Gen Hosp</i>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Mary Anna Arneel</i>		Fint	Middle	Last	4. DATE OF DEATH <i>16</i>	Month	Day Year <i>30 1958</i>
5. SEX <i>fe</i>		6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>4/15/86.</i>		9. AGE (In years last birthday) <i>71 yrs.</i>	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Federal Govt. Retired</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Virginia</i>		12. CITIZEN OF WHAT COUNTRY? <i>Amer.</i>	
13. FATHER'S NAME <i>Benjamin Parker</i>		14. MOTHER'S MAIDEN NAME <i>Mary WynKoop</i>				Address	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>pts hosp record-</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>acute heart failure</i> DUE TO <i>446x</i>						INTERVAL BETWEEN ONSET AND DEATH <i>sudden</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		(b) <i>uremia</i>				2 weeks	
		(c) <i>severe nephrosclerosis</i>				3 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>advanced cerebral sclerosis</i>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m.		20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>June 12, 1958</i> to <i>June 30, 1958</i> , that I last saw the deceased alive on <i>6/30</i> 1958, and that death occurred at <i>10:00 P.M.</i> from the causes and on the date stated above.				ADDRESS (Street, city or town, state) <i>M.D.</i>		DATE SIGNED <i>6/30/58</i>	
ACTUAL SIGNATURE <i>Daniel B. Washington MD</i>							
PHYSICIAN'S NAME (Type) <i>Daniel B. Washington MD</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>7-3-58</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>macedonia cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Frederick County, Va.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>James J. Collins 3371 14th St NW</i>		ADDRESS <i>14th St NW</i>		24a. REC'D BY REGISTRAR <i>100</i>		24b. REGISTRAR'S SIGNATURE <i>Autumn</i>	
				DATE <i>11/11/58</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

DECEASED PERSON'S NAME

MATERIAL TESTED

TESTS

STATE GOVERNMENT OF NEW YORK

DEPARTMENT OF HEALTH

REGISTRATION AND CERTIFICATION

DEATH CERTIFICATE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06933

6968 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. LENGTH OF STAY IN 1b 1½ yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 9101 LOUIS AVENUE		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING	
3. NAME OF DECEASED (Type or print) EMMA MATILDA		4. DATE OF DEATH Baker June 30 1958	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH 12/27/88
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sales check writer		10b. KIND OF BUSINESS OR INDUSTRY Hecht Dept. Store	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Frank Touschner		14. MOTHER'S MAIDEN NAME Mary Saxer	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 579-32-9273	
17. INFORMANT Mr. Frank J. Baker, 9101 Louis Ave., Silver Spring, Maryland		Address INTERVAL BETWEEN ONSET AND DEATH 6 hrs	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO Arterio Sclerosis Conditions, if any, which gave rise to immediate cause (a), isolating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 6 hrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from June 30, 1958 to June 30, 1958 , that I last saw the deceased alive on June 30, 1958 , and that death occurred at 9:45 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 1831 Yarmouth St N.E. DATE SIGNED Leland S. Madden			
ACTUAL SIGNATURE Leland S. Madden			
PHYSICIAN'S NAME (Type) Leland S. Madden Washington, D.C.			
22a. BURIAL, CREMATION, REMOVAL (Specify) TRANS. & BURIAL 7/3/58		22b. DATE THEREOF ST. BASIL CHURCH CEMETERY	
22c. LOCATION (City, town, or county) SHILOH, PENNSYLVANIA		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Warren E. Humphrey		24a. REC'D BY REGISTRAR DATE JUL 2 '58	
ADDRESS Silver Spring, Md.		24b. REGISTRAR'S SIGNATURE John Smith	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 1 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached from the certificate and given to the funeral director. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

STANDARD PRACTICE FOR THE TRANSFER OF LIQUID
FRACTIONATION STABILIZER

STABILIZER APPROVED - 2000

D

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
6969 CERTIFICATE OF DEATH

Reg. Dist. No. 215
06931

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

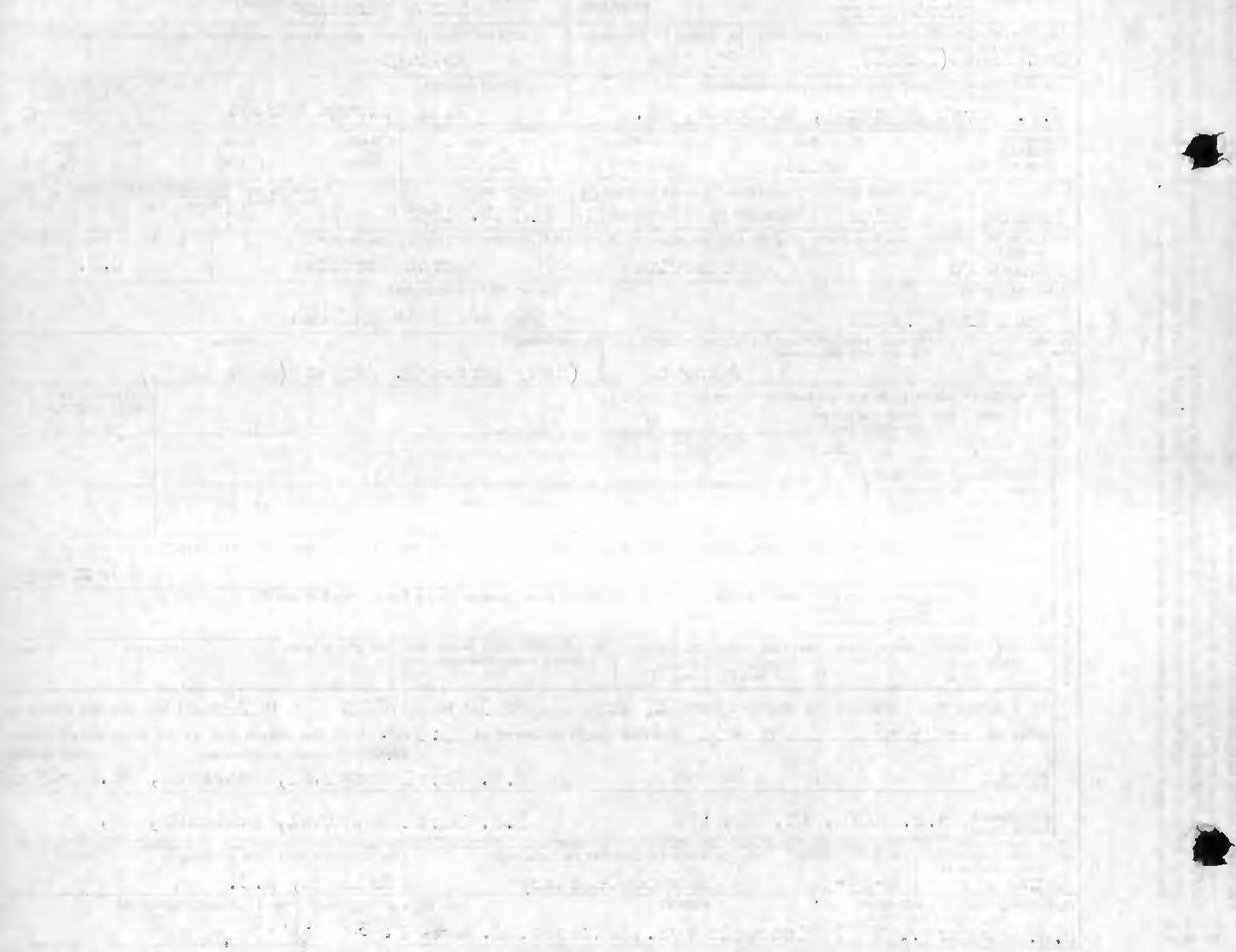
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE North Carolina		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN lb 31 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Raleigh		d. STREET ADDRESS 1111 Watauga Street	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Sallie	Middle Massey	Last BARBER	4. DATE OF DEATH	Month June	Day 18	Year 19 58
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 21 Feb. 1892	9. AGE (In years less birthday) 66	IF UNDER 1 YEAR Months 6	IF UNDER 24 HRS. Days 0	Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Housewife		11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Azel Grey MASSEY				14. MOTHER'S MAIDEN NAME Duo Adelphia GRIFFEN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT (Son) Horace M. Barber (Same As #2)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 571.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) Hepatic Coma Faemne's Cirrhosis							
INTERVAL BETWEEN ONSET AND DEATH 2 weeks.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 17 May 19 58 to 18 June 19 58 , that I last saw the deceased alive on 18 June 19 58 , and that death occurred at 3:50PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE R.G. Muth							
ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md.							
DATE SIGNED 6-19-58							
PHYSICIAN'S NAME (Type) R.G. MUTH, LT, MC, USN		U.S. Naval Hospital, Bethesda, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-23-58		22c. NAME OF CEMETERY OR CREMATORIUM Oakwood Cemetery		22d. LOCATION (City, town, or county) (State) Raleigh, N.C.	
23. FUNERAL DIRECTOR'S SIGNATURE R.A. Pumphrey, 7557 Wisconsin Ave., Bethesda, Md.		ADDRESS		24a. REC'D. BY REGISTRAR DATE JUN 23 1958		24b. REGISTRAR'S SIGNATURE C. H. Seach	

BY JOURNALIST-EDITOR OF THE STATE CHRONICLE

THE STATE CHRONICLE



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6970

CERTIFICATE OF DEATH

Reg. Dist. No.

06934

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		COUNTY Montgomery
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		c. LENGTH OF STAY IN 1b 5 hr. 22 mins.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville 26		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery County General Hospital		d. STREET ADDRESS 106 North Adams Street			e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print)	First Josephine	Middle McMorris	Last Barnes	4. DATE OF DEATH 6 20 1958	Month Day Year
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-5-1893	9. AGE (in years last birthday) 65 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) homemaker		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME George W. McMorris		14. MOTHER'S MAIDEN NAME Katherine Williams			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, unknown) no		16. SOCIAL SECURITY NO. none	17. INFORMANT A. Wilbur J. Barnes, 106 N. Adams St., Rockville, Md.	Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 33IX Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)		<i>Cerebral hemorrhage left hemisphere</i>			INTERVAL BETWEEN ONSET AND DEATH 7 hours.
DUE TO					
DUE TO					
(c)		<i>Arteriosclerosis & hypertension</i>			5 years.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County) (State)
21. I certify that I attended the deceased from 1950 , 19, to June 20, 1958 , that I last saw the deceased alive on June 20, 1958 , and that death occurred at 4:22 PM , from the causes and on the date stated above.					
ACTUAL SIGNATURE <i>W. A. Linthicum</i>		ADDRESS (Street, city or town, state) 26 N. Summit Ave., Gaithersburg, Md.			
DATE SIGNED 6/20/58					
PHYSICIAN'S NAME (Type) William A. Linthicum MD.					
22a. BURIAL CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 6/23/1958	22c. NAME OF CEMETERY OR CREMATORIUM Pohick Cemetery	22d. LOCATION (City, town, or county) Pohick, Virginia		(State)
23. FUNERAL DIRECTOR'S SIGNATURE Joseph Gauder's Sons		ADDRESS 1756 Pa. Ave., N. W. Washington, D. C.	24a. REC'D BY REGISTRAR JUN 23 '58	24b. REGISTRAR'S SIGNATURE Allie...eber	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06935

6971

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Md.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		b. COUNTY MONTGOMERY			
c. LENGTH OF STAY IN 1b SUBURBAN		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda Md.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS 8512 Haywood Rd.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First Abby	Middle Dani	Last BAYLY		
4. DATE OF DEATH	Month JUNE	Day 3	Year 1958		
5. SEX FEMALE	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/25/88		
9. AGE (In years last birthday) 70 yrs	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 8	12. Hours 0		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY Own home	11. BIRTHPLACE (State or foreign country) OHIO	12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Emerson W Price	14. MOTHER'S MAIDEN NAME Josephine Burgin	Address Son Charles B Bayly, Jr-50 Vanderbdt Ave. N.Y.			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No	16. SOCIAL SECURITY NO. —	17. INFORMANT Son			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute pulmonary edema DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last (b) congestive heart failure DUE TO (c) arteriosclerotic ht. disease + myocarditis DUE TO		INTERVAL BETWEEN ONSET AND DEATH 1 1/2 hrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —	20f. (City or town) —	(County) —	(State) —
21. I certify that I attended the deceased from Oct , 19 57 , to 3 June , 19 58 , that I last saw the deceased alive on 3 June , 19 58 , and that death occurred at 11:45 PM , from the causes and on the date stated above. ACTUAL SIGNATURE John M. Wyman PHYSICIAN'S NAME (Type) JOHN M. WYMAN					
ADDRESS (Street, city or town, state) 7659 Old Georgetown Rd. 6-4-58					
DATE SIGNED 6-4-58					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 6/6/58	22c. NAME OF CEMETERY OR CREMATORIUM Parklawn	22d. LOCATION (City, town, or county) Rockville, Maryland	(State) —	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey	ADDRESS Bethesda, Maryland	24a. REC'D BY REGISTRAR JUN 9 '58	24b. REGISTRAR'S SIGNATURE G. W. Research		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

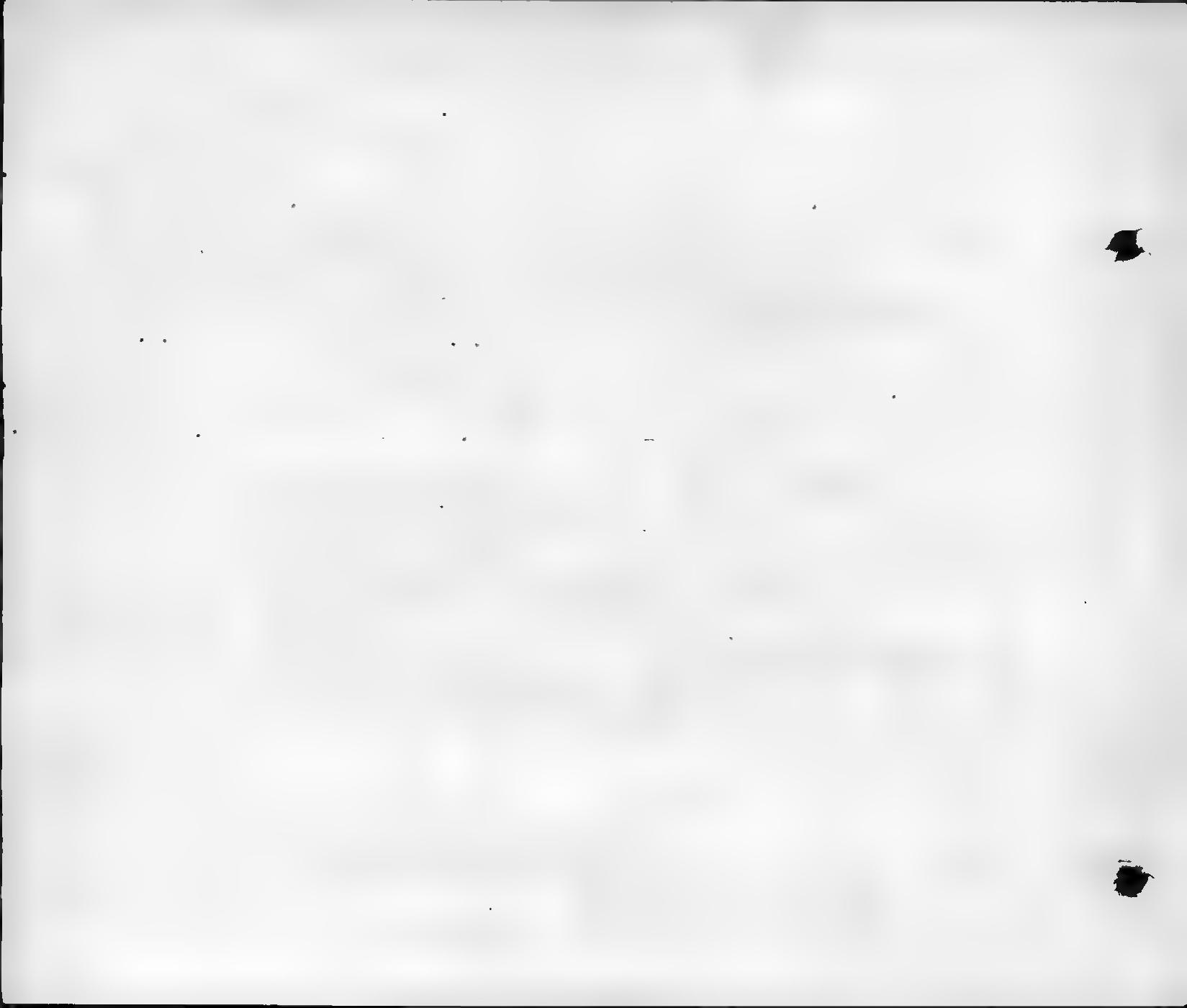


MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
6972 Item 117-175-1 CERTIFICATE OF DEATH

06936

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>			2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Montgomery</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Chevy Chase</i>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Chevy Chase</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Elmwood Hospital</i>			d. STREET ADDRESS <i>5421 Wooten Ave.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <i>HILTON</i>		First <i>HILTON</i>	Middle <i>WES</i>	Last <i>B EALL</i>	4. DATE OF DEATH Month Day Year <i>June 24, 1958</i>
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>July 19, 1873</i>	9. AGE (In years last birthday) <i>84</i> yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <i>D.C.</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>James H. Beall</i>			14. MOTHER'S MAIDEN NAME <i>Elizabeth Morgan</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <i>214-12-7838</i>	17. INFORMANT <i>Peter J.W. Beall</i>	Address <i>5421 Wooten Ave., Chevy Chase, Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Asymmetrical Cerebral Hemiparesis</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arteriosclerosis</i> DUE TO (c) <i>Senile degeneration of Arteriosclerotic Disease</i> INTERVAL BETWEEN ONSET AND DEATH <i>12 hrs</i>					
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Senility.</i>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	Day	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>3323 3rd St. N.W.</i>	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>July 15, 1957</i> to <i>June 24, 1958</i> that I last saw the deceased alive on <i>July 24, 1958</i> and that death occurred at <i>1 P.M.</i> from the causes and on the date stated above. ACTUAL SIGNATURE <i>Francis J. Keppe</i> M.D. ADDRESS (Street, city or town, state) <i>3323 3rd St. N.W. Washington 7 D.C.</i> DATE SIGNED					
22a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		22b. DATE THEREOF <i>6/27/58</i>		22c. NAME OF CEMETERY OR CREMATORIAL <i>Parklawn Cem.</i>	22d. LOCATION (City, town, or county) (State) <i>Washington, D.C.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Chevy Chase Funeral Home</i>			ADDRESS <i>5103 Wisconsin Ave.</i>	24a. REC'D BY REGISTRAR DATE <i>July 24, 1958</i>	24b. REGISTRAR'S SIGNATURE <i>W. Schaeffer</i>



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6937

CERTIFICATE OF DEATH

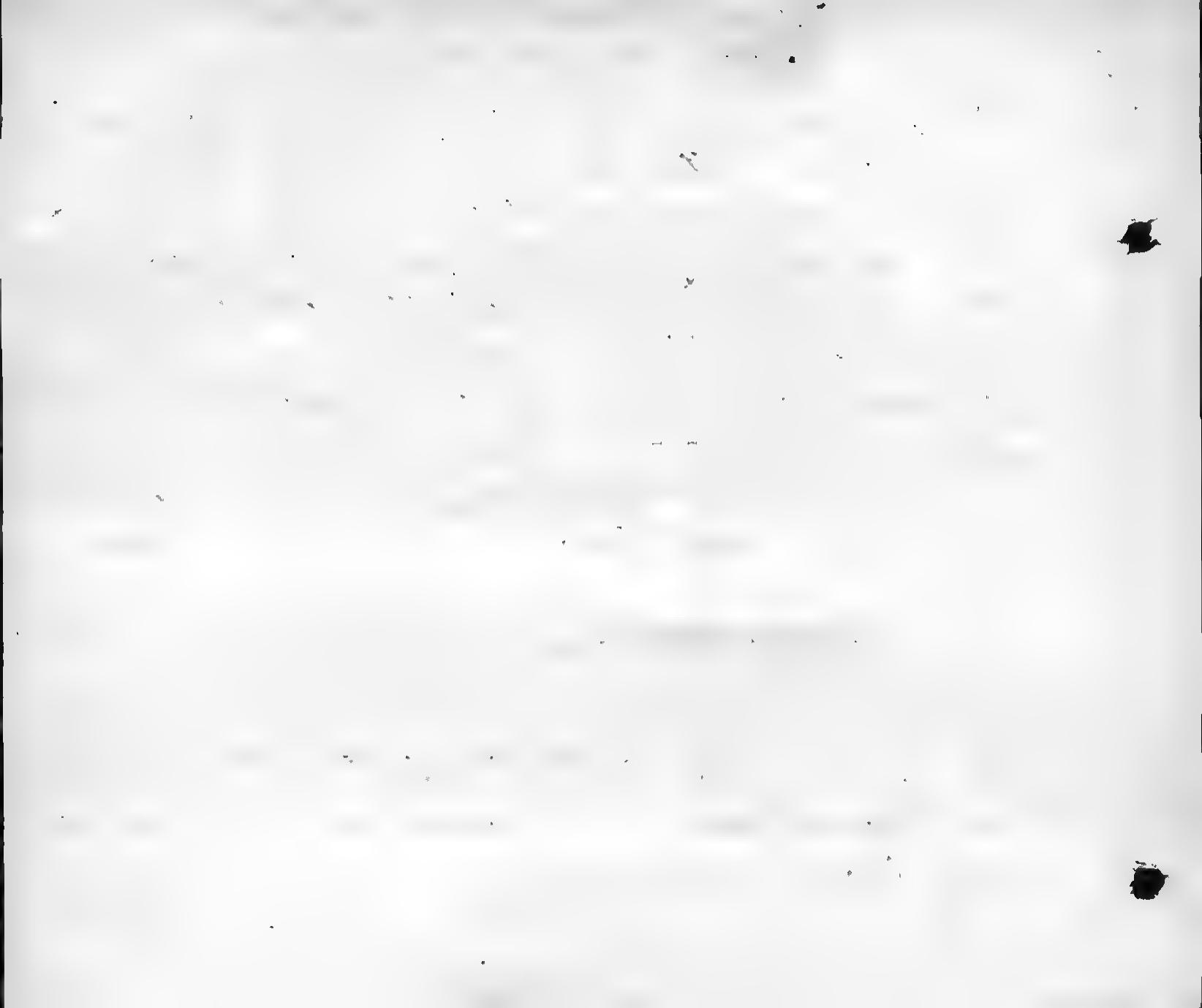
06937

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived II institution Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Montgomery</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		c. LENGTH OF STAY IN 1b <i>90 days</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>		d. STREET ADDRESS <i>#11 H. St. Rd.</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Washington Sanitarium & Hospital</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <i>William</i>		First <i>Floyd</i> Middle <i>Beasley</i> Last		4. DATE OF DEATH <i>June 16</i>		Month	Day	Year	
5. SEX <i>Male</i>		6. COLOR OR RACE <i>Caucasian</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>7-25-84</i>		9. AGE (In years last birthday) <i>78 yrs</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>engineer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>U.S. Army</i>		11. BIRTHPLACE (State or foreign country) <i>Ohio</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
13. FATHER'S NAME <i>Marshall Beasley</i>		14. MOTHER'S MAIDEN NAME <i>Eva E.</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO <i>578-32-7612</i>		17. INFORMANT <i>Hospital Records</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Hemorrhage</i> DUE TO Conditions if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) <i>Hypertension</i> DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH: <i>one month</i> <i>years</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Diabetes Mellitus</i>								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <i>Takoma Park, Md.</i>		(County)	(State)
21. I certify that I attended the deceased from <i>5-16-1958</i> to <i>6-16-1958</i> , that I last saw the deceased alive on <i>6-15-1958</i> , and that death occurred at <i>5:05 AM</i> , from the causes and on the date stated above.									
ACTUAL SIGNATURE <i>Robert A. Hare</i>		ADDRESS (Street, city or town, state) <i>M.D. Takoma Park, Md.</i>		DATE SIGNED <i>6/16/58</i>					
PHYSICIAN'S NAME (Type) <i>Robert A. Hare, M.D.</i>									
22a. BURIAL CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF <i>6/18/58</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>CEDAR HILL CEMETERY</i>		22d. LOCATION (City, town, or county) <i>PRINCE GEO. COUNTY, MARYLAND</i>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Walker L. Humphrey</i>		ADDRESS <i>SILVER SPRING, MD.</i>		24a. REC'D BY REGISTRAR DATE JUN 17 '58		24b. REGISTRAR'S SIGNATURE <i>DeLoach</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06938

6938

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Montgomery</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		c. LENGTH OF STAY IN 1b <i>25 days 7 mts.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park, Md.</i>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Washington Sanitarium & Hospital</i>		d. STREET ADDRESS <i>6505 Eastmoreland Ave.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <i>Baby</i>		First	Middle	Last	4. DATE OF DEATH <i>Benson</i>	Month	Day	Year	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>6/13/58</i>	9. AGE (In years from birthday) yrs <i>6</i>	10. IF UNDER 1 YEAR Months <i>28</i>	11. IF UNDER 24 HRS Hours <i>7</i>	12. IF UNDER 24 HRS Min <i>7</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>U. S. A.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>			
13. FATHER'S NAME <i>Harold George Benson</i>		14. MOTHER'S MAIDEN NAME <i>Judith Anne Becktel</i>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown) <i>No</i>		16. SOCIAL SECURITY NO		17. INFORMANT <i>Mother's chart</i>		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Inaturity</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. <i>1100</i> (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <i>28 hrs.</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>6-15-58</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>613 Spring St.</i>		20f. (City or town) <i>Takoma Park</i>		(County) <i>M.D.</i>	(State) <i>Md.</i>
21. I certify that I attended the deceased from <i>6/12</i> , 1958, to <i>6/13</i> , 1958, that I last saw the deceased alive on <i>6/13/58</i> , 1958, and that death occurred on <i>6/14</i> , 1958, from the causes and on the date stated above. ACTUAL SIGNATURE <i>H. H. Diamond</i>						ADDRESS (Street, city or town, state) <i>8224-9a Ave.</i>			DATE SIGNED <i>6/13/58</i>
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Cremation</i>		22b. DATE THEREOF <i>6-15-58</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Washington Sanitarium and Hospital</i>		22d. LOCATION (City, town, or county) <i>Takoma Park, Md.</i>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert O'Hare III</i>		ADDRESS <i>Takoma Park, Md.</i>		24a. REC'D BY REGISTRAR DATE <i>SUN 20 '58</i>		24b. REGISTRAR'S SIGNATURE <i>Allred</i>			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
6939
CERTIFICATE OF DEATH

06939

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK		c. LENGTH OF STAY IN 1b 2½ months		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING						
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUT ON 7300 BALTIMORE AVENUE Cedar Haven Rest Home				d. STREET ADDRESS 804 DALE DRIVE						
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
3. NAME OF DECEASED (Type or print) JETTIE		First MIDDLE KEMPER		4. DATE OF DEATH BISHOP		Month JUNE	Day 2	Year 58 19		
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11/5/73		9. AGE (In years last birthday) 84 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOMEMAKER		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (State or foreign country) VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME GEORGE A. SEAGLE		14. MOTHER'S MAIDEN NAME ELIZABETH WELSH		Address Alfred E. Fivaz, 804 Dale Drive, Silver Spring, Maryland						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT Alfred E. Fivaz, 804 Dale Drive, Silver Spring, Maryland		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Medical pt removed.</i> <i>411X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 7/10/58	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <i>Cardiovascular heart disease, myopathy.</i>								
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from <i>6/1/58</i> , to <i>6/11/58</i> , that I last saw the deceased alive on <i>6/11/58</i> , and that death occurred at <i>3408</i> M, from the causes and on the date stated above. ACTUAL SIGNATURE <i>James R. Coleman, M.D.</i> ADDRESS (Street, city or town, state) <i>113 Carroll St NW Washington D.C.</i> DATE SIGNED <i>6/12/58</i>										
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL 6/4/58		22b. DATE THEREOF 6/4/58		22c. NAME OF CEMETERY OR CREMATORIUM ROCK CREEK CEMETERY		22d. LOCATION (City, town, or county) WASHINGTON, D.C. (State)				
23. FUNERAL DIRECTOR'S SIGNATURE <i>Warren E. Lumphrey</i>			ADDRESS SILVER SPRING, MD.		24a. REC'D BY REGISTRAR DATE JUN 4 '58		24b. REGISTRAR'S SIGNATURE <i>John Smith</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4.

TO FUNERAL DIRECTOR: After his certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Page 4, 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



FOR STATE
HEALTH DEPT.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Chief Medical Examiner's Office along with form PM3. Page 5 may be forwarded to the Chief Medical Examiner's Office along with form PM3. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15ME
AM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6973 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06940

Reg. Dist. No.

Item 3, Film G-231 7/7/58.cac

1. PLACE OF DEATH

a. COUNTY

Montgomery

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Springfield

c. LENGTH OF STAY IN 16

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

5613 Parkston Road

3. NAME OF
DECEASED
(Type or print)

First: Phillipps Middle: Wendell Surname: Blake

4. SEX

Male

5. COLOR OR RACE

White

6. MARRIED
WIDOWED
DIVORCEDMARRIED NEVER MARRIED DIVORCED

7. DATE OF BIRTH

Nov. 18 1688

8. DATE OF
BIRTHPLACE (State or foreign country)

69 yrs

9. AGE IN YEARS
(not birthday)

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Retired Navy Capt.

11. KIND OF BUSINESS OR INDUSTRY

U.S. Govt

12. BIRTHPLACE (State or foreign country)

New Hampshire

13. FATHER'S NAME

Eugene L. Blake

14. MOTHER'S MAIDEN NAME

Jessie Adams

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

578-50-1014

17. INFORMANT

Betty J. Blake-Same Item #2

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Coronary Occlusion

DUE TO

Conditions, if any, which

gave rise to immediate cause

(a), stating the underlying

cause last.

(b)

DUE TO

(c)

DUE TO

(d)

DUE TO

(e)

DUE TO

(f)

DUE TO

(g)

DUE TO

(h)

DUE TO

(i)

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(j)

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DUE TO

(yy)

DUE TO

(zz)

DUE TO

INTERVAL BETWEEN
ONSET AND DEATH
sudden

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. a. WAS AUTOPSY PERFORMED?

YES NO b. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH.c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m.
19d. INJURY OCCURRED While at work Not while at work

e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

f. (City or town) (County) (State)

g. 21. I certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry , and in my opinion death resulted from: Natural causes , Accident , Suicide , Homicide , Undetermined manner h. ACTUAL SIGNATURE *Frank J. Broschart*

i. EXAMINER'S NAME (Type) Frank J. Broschart, M.D.

j. CHIEF MEDICAL EXAMINER ASSISTANT MEDICAL EXAMINER DEPUTY MEDICAL EXAMINER

k. DATE SIGNED June 25, 1958

l. BURIAL, CREMATION REMOVAL (Specify) 6/27/1958

m. NAME OF CEMETERY OR CREMATORIAL ADDRESS Arlington National Cemetery

n. LOCATION (City, town, or county) Arlington Virginia

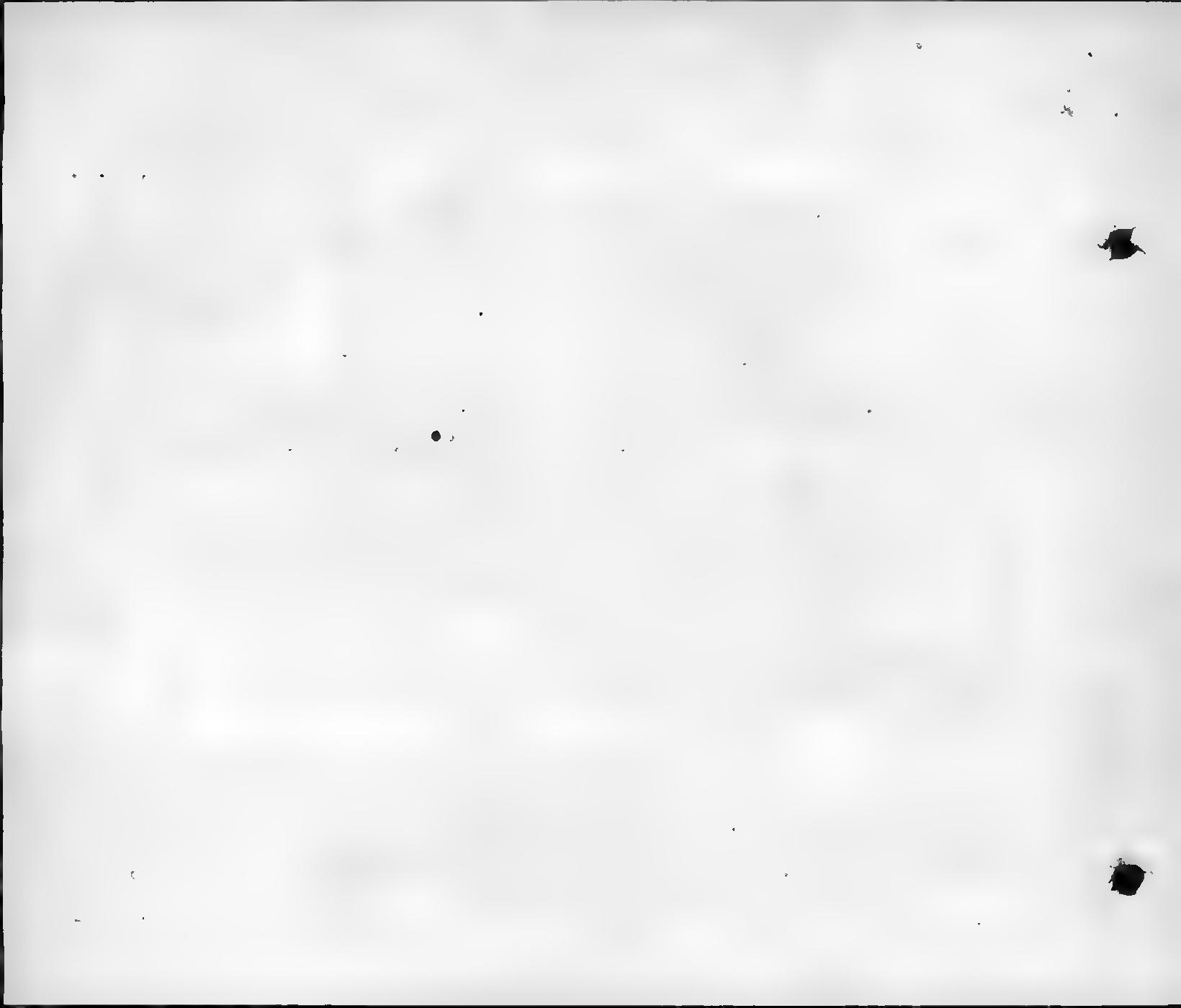
o. REC'D BY REGISTRAR June 27 1958

p. REGISTRAR'S SIGNATURE *Alfred E. Smith*

q. FUNERAL DIRECTOR'S SIGNATURE Robert A. Humphrey-7557 Wisconsin Ave, Bethesda

r. DATE JUN 27 1958

s. VS A15ME AM 2/57



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6974

CERTIFICATE OF DEATH

06941

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. LENGTH OF STAY IN 1b 17 yrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 802 THAYER AVE.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING	
3. NAME OF DECEASED (Type or print) FRANCES CLARK Boehm		d. STREET ADDRESS 802 THAYER AVE	
5. SEX F	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MARCH 13, 1906
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		9. AGE (In years lost birthday) 52 yrs.	
10b. KIND OF BUSINESS OR INDUSTRY		10. BIRTHPLACE (State or foreign country) HYATTSVILLE MD	
11. CITIZEN OF WHAT COUNTRY? U.S.A.		12. MOTHER'S MAIDEN NAME EMMA IRENE Boswell	
13. FATHER'S NAME HERBERT Allen Osborn		14. Address 8204 Cedar St 55A6	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) NO		16. SOCIAL SECURITY NO 220-34-8114	
17. INFORMANT R. A. OSBOURN		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a). X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO	
		Broncho pneumonia Carcinoma of Breast - with Metastases 6 years	
		INTERVAL BETWEEN ONSET AND DEATH 3 days	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Hypertension	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from September, 1950, to 6-6, 1958, that I last saw the deceased alive on 6-3, 1958, and that death occurred at 5:30 PM, from the causes and on the date stated above. ACTUAL SIGNATURE Michael J. McInerney M.D. ADDRESS (Street, city or town, state) 1150 - Conn Acreal DATE SIGNED 6-6-58			
PHYSICIAN'S NAME (Type) MICHAEL J. MCINERNEY		22d. LOCATION (City, town, or county) WASH. D. C. (State)	
22a. BURIAL CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF JUNE 9, 1958	
22c. NAME OF CEMETERY OR CREMATORIUM MI. OLIVET		22d. LOCATION (City, town, or county) WASH. D. C. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE W. W. TALTAVULL		ADDRESS 3603 14 th SW	
		24a. REC'D BY REGISTRAR DATE JUN 9 '58	
		24b. REGISTRAR'S SIGNATURE	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6975

CERTIFICATE OF DEATH

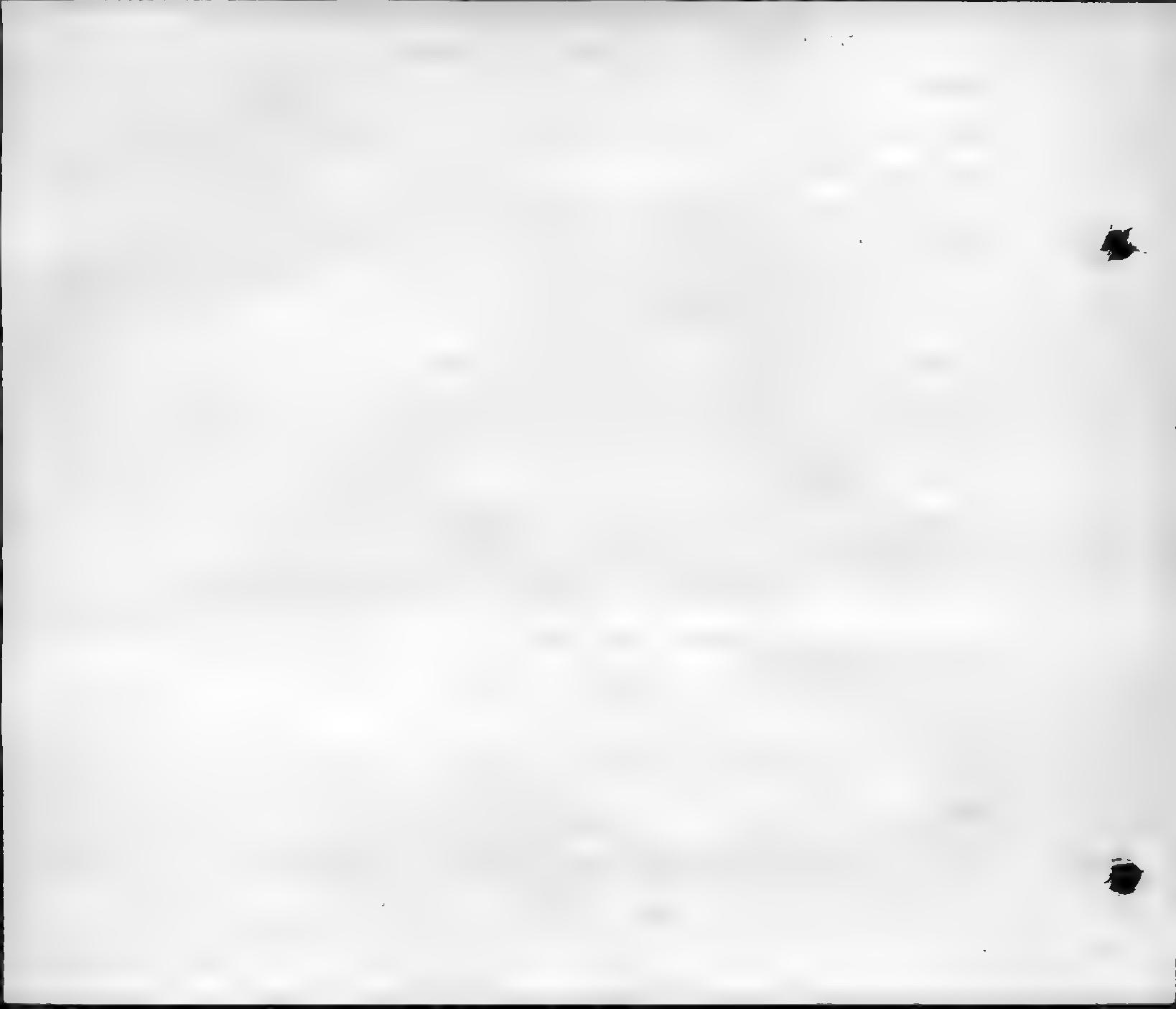
06942

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Page 1 and 2 should be filed with the register prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Baltimore City</i>		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <i>MARYLAND</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>	c. LENGTH OF STAY IN 1b <i>18 mos</i>	d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>1721 Connecticut Ave</i>		e. STREET ADDRESS <i>1721 Connecticut Ave</i>	
3. NAME OF DECEASED (Type or print) <i>HARRY</i>		4. DATE OF DEATH <i>DEC 5 1958</i>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
5. SEX <i>MALE</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>MARCH 21 1973</i>
9. AGE (In years lost birthday) <i>83 yrs</i>		10. IF UNDER 1 YEAR Months <i>0</i> Days <i>0</i>	11. IF UNDER 24 HRS Hours <i>0</i> Min. <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Citizen Farmer Retired</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>None</i>	
11. BIRTHPLACE (State or foreign country) <i>Poland</i>		12. CITIZEN OF WHAT COUNTRY? <i>United States</i>	
13. FATHER'S NAME <i>ABRAHAM SHEKTEL</i>		14. MOTHER'S MAIDEN NAME <i>LEAH</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown) <i>No</i>		16. SOCIAL SECURITY NO <i>123-45-6789</i>	
17. INFORMANT <i>Mr. & Mrs. Abraham ShekTEL</i>		Address <i>47421 Connecticut Ave</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>PCV in heart failure</i>		INTERVAL BETWEEN ONSET AND DEATH <i>1 day</i>	
DUE TO <i>Mr. L. A. Oskaroff's condition was so bad he died</i>		<i>2 days</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) <i>and</i> (c) <i>in view of Dr. A. L. L. H. H.</i>		<i>of metastases</i>	
DUE TO <i>metastases</i>		<i>of metastases</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>JUNE 1, 1958</i> , to <i>JUNE 6, 1958</i> , that I last saw the deceased alive on <i>JUNE 6, 1958</i> , and that death occurred at <i>11 P.M.</i> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <i>Robert L. Friedman, M.D.</i>		DATE SIGNED <i>7-2-58</i>	
PHYSICIAN'S NAME (Type) <i>Robert L. Friedman, M.D.</i>			
22a. BURIAL CREMATION, REMOVAL (Specify) <i>Cremation</i>		22b. DATE THEREOF <i>6/9/1958</i>	
22c. NAME OF CEMETERY OR CREMATORIAL <i>Cedar Hill</i>		22d. LOCATION (City, town, or county) <i>Baltimore</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>R. Goldberg</i>		ADDRESS <i>Washington, D.C.</i>	
24a. REC'D BY REGISTRAR DATE <i>JUN 9 '58</i>		24b. REGISTRAR'S SIGNATURE <i>W. E. Egan</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 6976 CERTIFICATE OF DEATH										06943					
1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND					2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Maryland					Reg. Dist. No. 215					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)					c. LENGTH OF STAY IN 1b 5 days					d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Easton					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Maryland					e. STREET ADDRESS 123 West Street					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First Frederick	Middle Charles	Last OWERFIND	4. DATE OF DEATH June 21 1958		Month June	Day 21	Year 1958						
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 28 March 1886		9. AGE (In years lost birthday) 72 yrs	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mariner		11. KIND OF BUSINESS OR INDUSTRY U.S. Navy Retired		12. BIRTHPLACE (State or foreign country) Michigan		IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS
13. FATHER'S NAME Frederick BOWERFIND										14. MOTHER'S MAIDEN NAME Lilly SIHLER					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) WW-I, WW-II		17. INFORMANT (Wife) Mrs. Frances C. BOWERFIND (Same as #2)		Address									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) 199.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										INTERVAL BETWEEN ONSET AND DEATH 6 mos					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20c. TIME OF INJURY Hour a. m. p. m.		Month 19	Doy 19	Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Arlington		(County) Fairfax		(State) Virginia		
21. I certify that I attended the deceased from 16 June 1958 to 21 June 1958, that I last saw the deceased alive on 21 June 1958, and that death occurred at 11:25 P.M. from the causes and on the date stated above.										ADDRESS (Street, city or town, state) George W. Taylor, Jr., CDR, MC, USN M.D. U.S. Naval Hospital, Bethesda, Md. 6-23-58					
ACTUAL SIGNATURE George W. Taylor, Jr., CDR, MC, USN PHYSICIAN'S NAME (Type) GEORGE W TAYLOR, JR. CDR, MC, USN U. S. Naval Hospital, Bethesda, Md.										DATE SIGNED 6-23-58					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-26-58		22c. NAME OF CEMETERY OR CREMATORIAL Arlington Nat'l Cemetery			22d. LOCATION (City, town, or county) Arlington, Virginia		(State)						
23. FUNERAL DIRECTOR'S SIGNATURE Joseph Gaylor's Sons		ADDRESS Washington, D.C. 1756 Pennsylvania Ave, N.W.		24a. REC'D BY REGISTRAR JUN 24 '58			24b. REGISTRAR'S SIGNATURE Albert L. Sease								



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06944

FOR STATE
HEALTH DEPT.

H

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the Chief Medical Examiner. Page 4 is to be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the Store Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH		6977		Reg. Dist. No.	
a. COUNTY		MONTGOMERY MARYLAND		Where deceased lived. If institution Residence before admission	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		SILVER SPRING 2 days		c. STATE FLORIDA	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				b. COUNTY	
10. 707 LOCKRIDGE DRIVE		ORMOND BEACH		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
3. NAME OF DECEASED (Type or print)		d. STREET ADDRESS		d. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
JOHN WESLEY BOWLBY		48 PALMETTO DRIVE		4. DATE OF DEATH JUNE 15 Month Day Year JUNE 15 1958	
5. SEX male white		5. COLOR OR RACE 6. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 7. DATE OF BIRTH JUNE 15, 1880		9. AGE (in years from birthday) 78 yrs. IF UNDER 1 YEAR Months Days Hours Min	
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		10b. KIND OF BUSINESS OR INDUSTRY MEN'S CLOTHING		11. BIRTHPLACE (State or foreign country) PHILLIPSBURG, N. J.	
13. FATHER'S NAME ROBERT BOWLBY		14. MOTHER'S MAIDEN NAME ELIZABETH JOHNSON		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? NO		16. SOCIAL SECURITY NO. 126-12-1410		Address (Beach, Fla.)	
(Yes, no, or unknown) (If yes, give name or dates of service)		17. INFORMANT Mrs. John W. Bowlby, 48 Palmetto Dr., Ormond		INTERVAL BETWEEN ONSET AND DEATH sudden	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary occlusion 4/11 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AN AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accidental <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <i>Frank J. Broschart</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED June 15, 1958	
EXAMINER'S NAME (Type) FRANK J. BROSCHEIT		22a. BURIAL, CREMATION [22b. DATE THEREOF REMOVAL (Specify)] TRANS. & BURIAL 6/18/58		22c. NAME OF CEMETERY OR CREMATORIUM EAST BLOOMFIELD CEMETERY 22d. LOCATION (City, town, or county) EAST BLOOMFIELD, NEW YORK (State)	
22e. FUNERAL DIRECTOR'S SIGNATURE <i>Walker L. Pumpelly</i>		ADDRESS SILVER SPRING, MD.		24a. REC'D BY REGISTRAR JUN 17 '58 24b. REGISTRAR'S SIGNATURE <i>C. Schaefer</i>	
VS ATSM 6M 2 57					



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

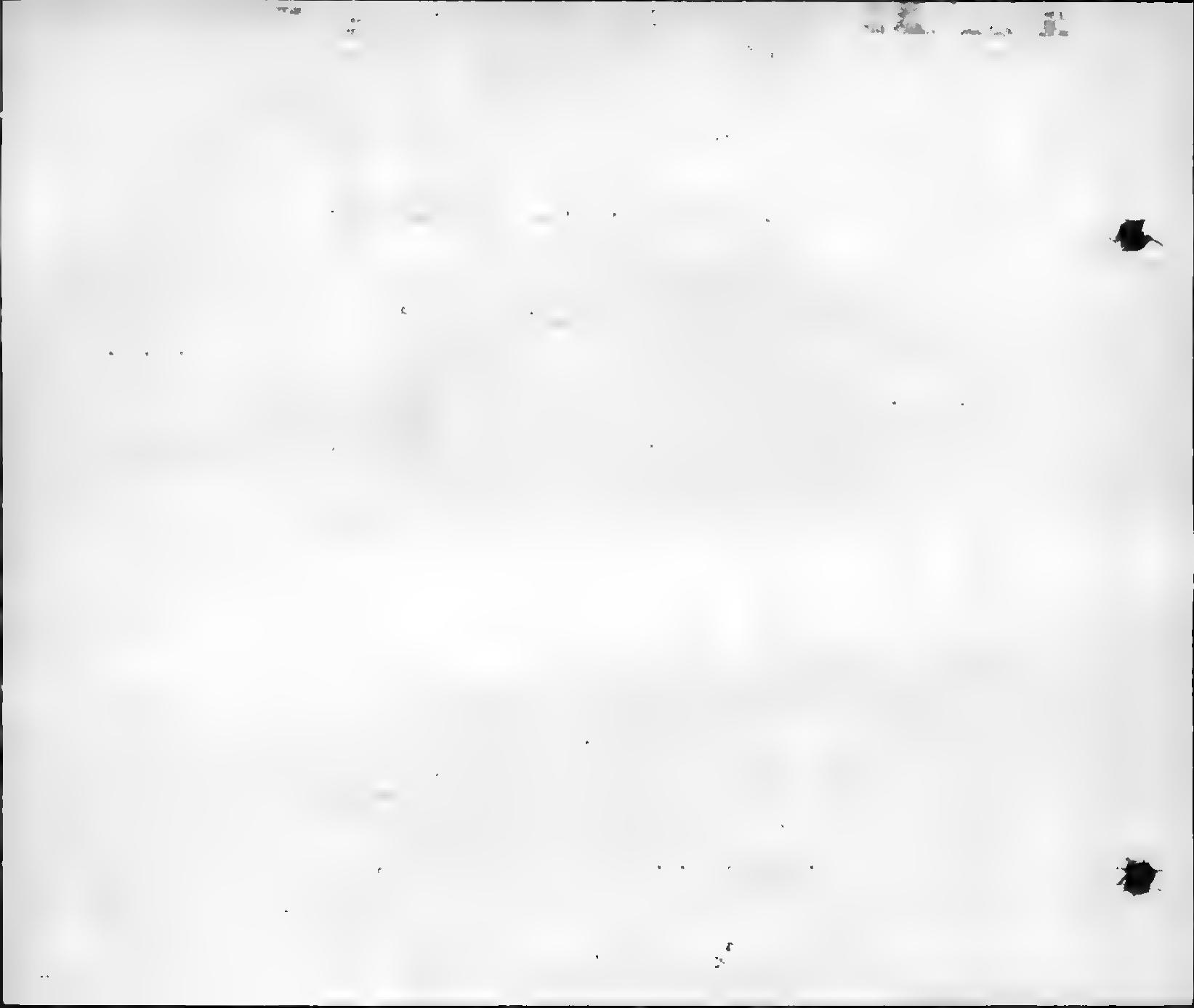
6978

CERTIFICATE OF DEATH

Reg. Dist. No.

06945

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Kentucky		b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 22 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Happy		d. STREET ADDRESS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.									
3. NAME OF DECEASED (Type or print)		First Hargis	Middle (None)	Last Brashears	4. DATE OF DEATH	Month June	Day 21	Year 1958	
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH January 27, 1909	9. AGE (In years lost birthday) 49 yrs.	10. IF UNDER 1 YEAR OR UNDER 24 HRS Months 0	Days 0	Hours 0	Min 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Coal Miner		10b. KIND OF BUSINESS OR INDUSTRY Mining		11. BIRTHPLACE (State or foreign country) Kentucky		12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME Robert L. Brashears				14. MOTHER'S MAIDEN NAME Margaret Combs					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown) Yes		16. SOCIAL SECURITY NO 1928-1931		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Possible Acute Leukemia						INTERVAL BETWEEN ONSET AND DEATH 3 Months			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. DUE TO		(b) DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from _____ May 30, 1958, to June 21, 1958, that I last saw the deceased alive on _____ June 21, 1958, and that death occurred at 1:15 P.M. from the causes and on the date stated above. ACTUAL SIGNATURE <i>Leon G. Smith</i>						ADDRESS (Street, city or town, state) The Clinical Center			
PHYSICIAN'S NAME (Type) LEON G. SMITH, M.D.						DATE SIGNED 6/21/58			
22a. BURIAL CREMATION REMOVAL (Specify) Cremation		22b. DATE THEREOF 6-22-58		22c. NAME OF CEMETERY OR CREMATORIUM Riverside Cemetery, Hazard, Ky.		22d. LOCATION (City, town, or county) Hazard, Ky.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co.		ADDRESS 2901 14th St. N.W., Washington, D.C.		24a. REG'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE <i>Audrey J. Anderson</i>					



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 1c File G230 6-16-58 et

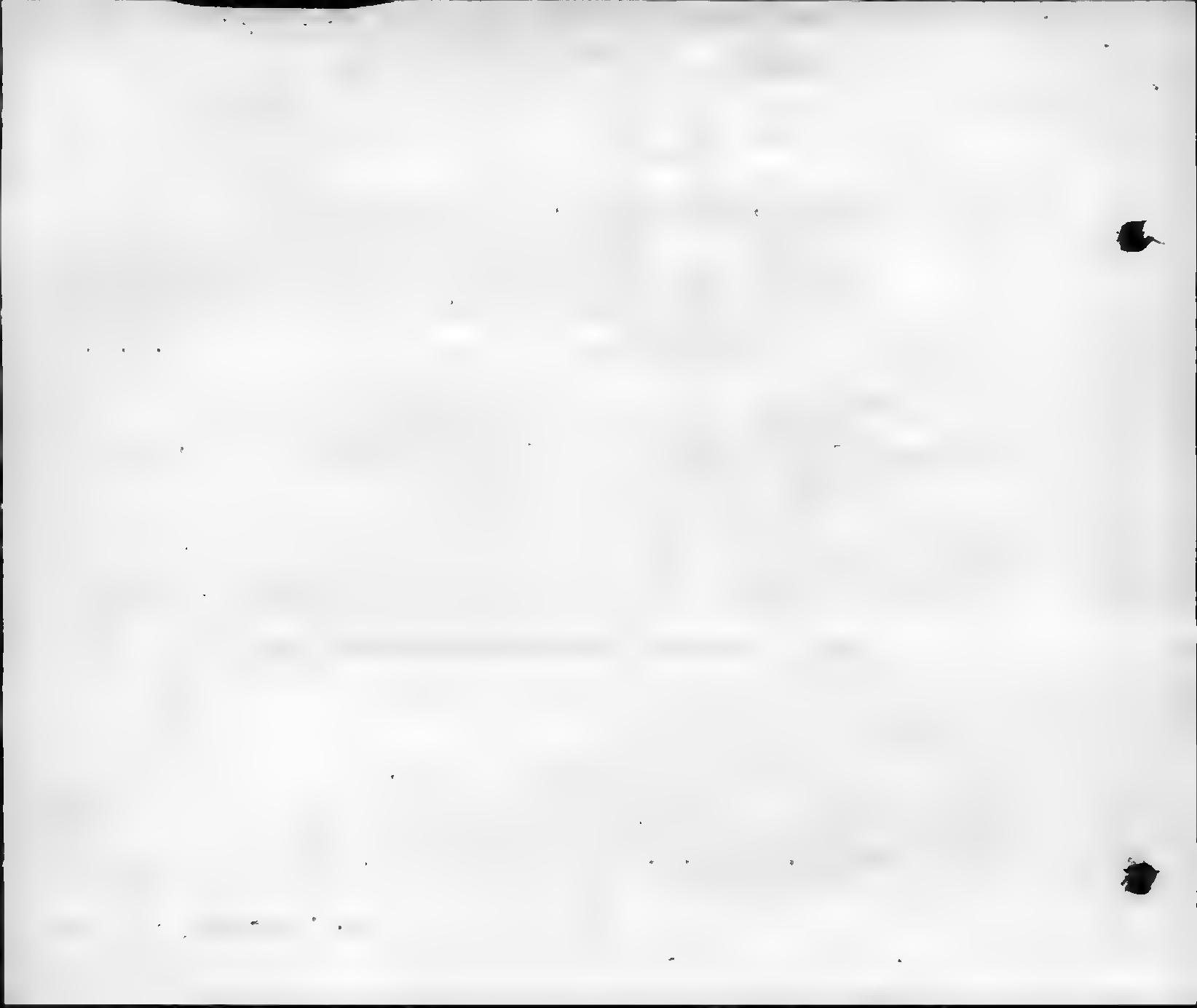
06946

6979

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland		b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 3488 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS 7800 Wisconsin Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Willard	Middle Abner	Last Braswell	4. DATE OF DEATH May 14, 1902	Month June	Day 10	Year 19 58
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH May 14, 1902	9. AGE (In years last birthday) 56 yrs	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0	12. IF UNDER 24 HRS Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Taxi Driver		10b. KIND OF BUSINESS OR INDUSTRY Passenger Transportation		11. BIRTHPLACE (State or foreign country) Georgia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Lee Andrew Braswell			14. MOTHER'S MAIDEN NAME Mary Etta Davis				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) yes		16. SOCIAL SECURITY NO 1920-1923		17. INFORMANT The Medical Record The Clinical Center, Bethesda 14, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Hepatic Failure					INTERVAL BETWEEN ONSET AND DEATH
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause at		Portal cirrhosis					? yrs.
(b)							
DUE TO Underlying cause at		Epidermoid carcinoma of Hypopharynx					6 mos.
(c)							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
19							
21. I certify that I attended the deceased from May 7, 1958, to 10 June, 1958, that I last saw the deceased alive on 10 June, 1958, and that death occurred at 2:45A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Robert C. Hoye, M.D.</i>				ADDRESS (Street, city or town, state) The Clinical Center National Institutes of Health Bethesda 14, Maryland			
PHYSICIAN'S NAME (Type) Robert C. Hoye, M. D.		DATE SIGNED 6/10/58					
22a. BURIAL, CREMATION, REMOVAL (Specify) Transit		22b. DATE THEREOF 6/11/58		22c. NAME OF CEMETERY OR CREMATORIUM		22d. LOCATION (City, town, or county) St. Augustine, Florida (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Maryland		ADDRESS 24a. REC'D BY REGISTRAR 24b. TWO STAMPS DATE JUN 13 '58 Albert J. Schuck					



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

06947

1. PLACE OF DEATH a. COUNTY		6980 Montgomery Silver Spring	2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE		MD	b. COUNTY	Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Silver Spring					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		Brooke Grove Foundation	d. STREET ADDRESS		8724 Cameron St.					
3. NAME OF DECEASED (Type or print)		First Ella	Middle Lee	Last Brider	4. DATE OF DEATH	Month June	Day 1	Year 1958		
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (in years last birthday)	10. IF UNDER 1 YEAR	11. IF UNDER 24 HRS			
				Jan. 7-1872	86 yrs.	Months	Days	Hours	Min.	
10a. USUAL OCCUPATION (Give kind of work done during working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?				
Domestic		Own Home		Lewiston No. Carolina		USA				
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		15. INFORMANT		16. ADDRESS				
James B. Saunders		Evelyn Barrett		Dr. Roy Brider		1534 East West Highway Silver Spring-Md				
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		19. INTERVAL BETWEEN ONSET AND DEATH						
(If yes, give war or date of service)		PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) 400.0		X 72						
{ Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first.		DUE TO (b) DUE TO (c)		X 75						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		Coronary Occlusion Arteriosclerotic Heart Disease		X 75						
20a. MEDICAL CERTIFICATION		20b. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. ACTUAL SIGNATURE		21. I certify that I attended the deceased from 3/22, 1958, to 6/1, 1958, that I last saw the deceased alive on 5/1, 1958, and that death occurred at 5:28 P.M., from the causes and on the date stated above.		ADDRESS (Street, city or town, state)		DATE SIGNED 6/1/58				
PHYSICIAN'S NAME (Type)		C. H. L. GORN		M.D.						
22a. BURIAL, CREMATION, BUT NOT Cremation (Specify)		22b. DATE THEREOF June 3		22c. NAME OF CEMETERY OR CREMATORIAL Hoggard Memorial		22d. LOCATION (City, town, or county) Lewiston, North Carolina		(State)		
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS Laytonsville, Md.		24a. REC'D BY REGISTRAR DATE JUN 4 '58		24b. REGISTRAR'S SIGNATURE Ulrich				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 3 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10

11

12 13

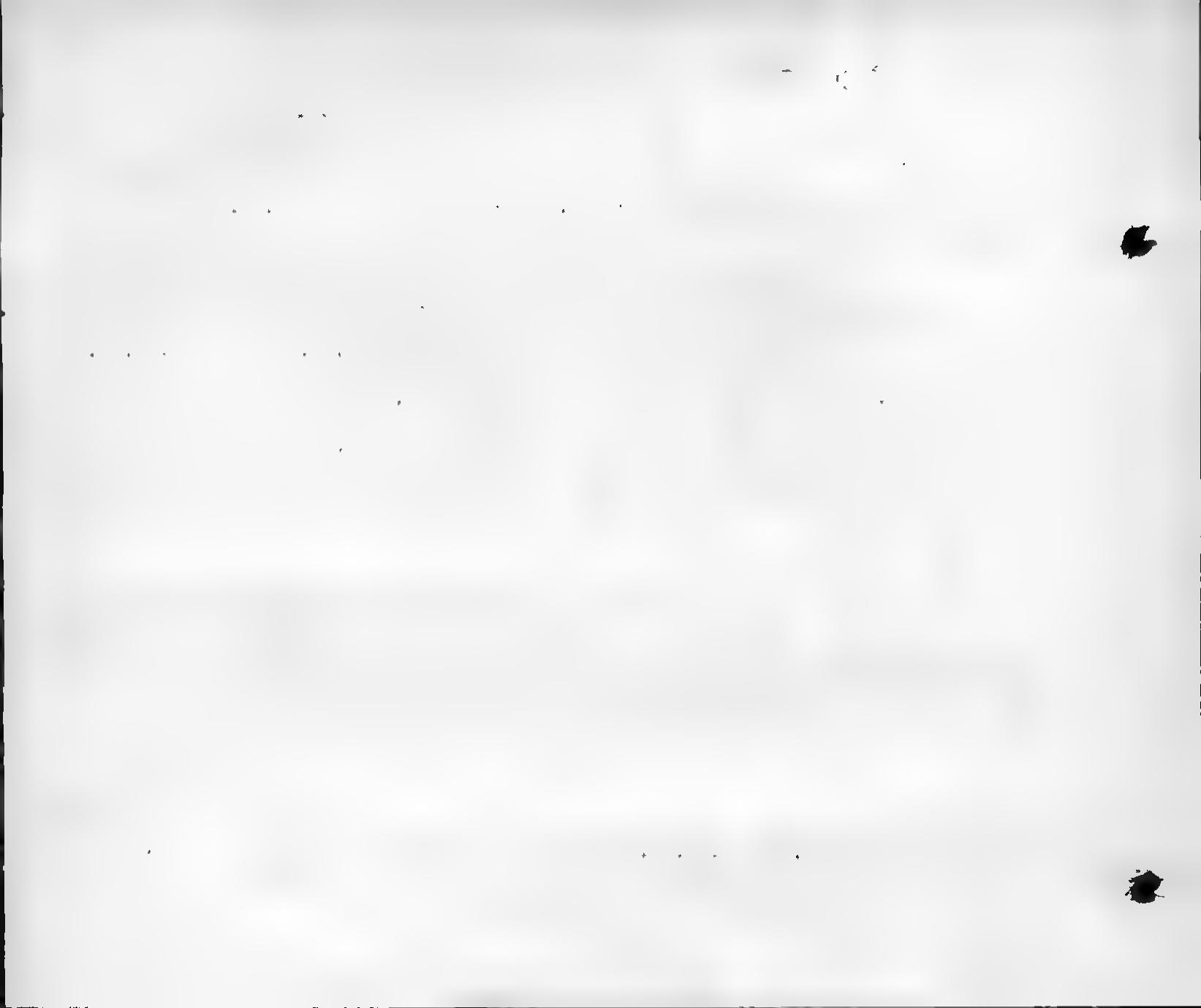
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06948

6981 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) a. STATE Washington, D.C. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN lb 4 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) District of Columbia	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS 3001 Nelson Place, S. E.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First Marie	Middle Teresa	Last Brown	4. DATE OF DEATH June 25, 1958	Month Day Year
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH October 29, 1954	9. AGE (In years lost birthday) 3 yrs	IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Washington, D. C.	
				12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Russell P. Brown		14. MOTHER'S MAIDEN NAME Teresa M. Luskey			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO None		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost.		Mucopurulent tracheobronchitis + bronch pneumonia		INTERVAL BETWEEN ONSET AND DEATH 2 days	
(b) DUE TO Acute lymphocytic leukemia				10 mos	
(c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 21, 1958, to June 25, 1958, that I last saw the deceased alive on June 25, 1958, and that death occurred at 12:50 AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state)					
ACTUAL SIGNATURE Edward W. Moore	M.D.		The Clinical Center		DATE SIGNED 6/25/58
PHYSICIAN'S NAME (Type) Edward W. Moore, M. D.			National Institutes of Health Bethesda 14, Maryland		
22a. BURIAL, CREMAT. ON, REMOVAL (Specify) Burial	22b. DATE THEREOF 6-27-58	22c. NAME OF CEMETERY OR CREMATORIUM Mt. Olivet Cemetery	22d. LOCATION (City, town, or county) Wash. D. C.	(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Reggie Kalik - 741-11th St. N. E.	ADDRESS Wash. D. C.	24a. REC'D BY REGISTRAR DATE JUN 30 '58	24b. REGISTRAR'S SIGNATURE Allison		



MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

6982

CERTIFICATE OF DEATH

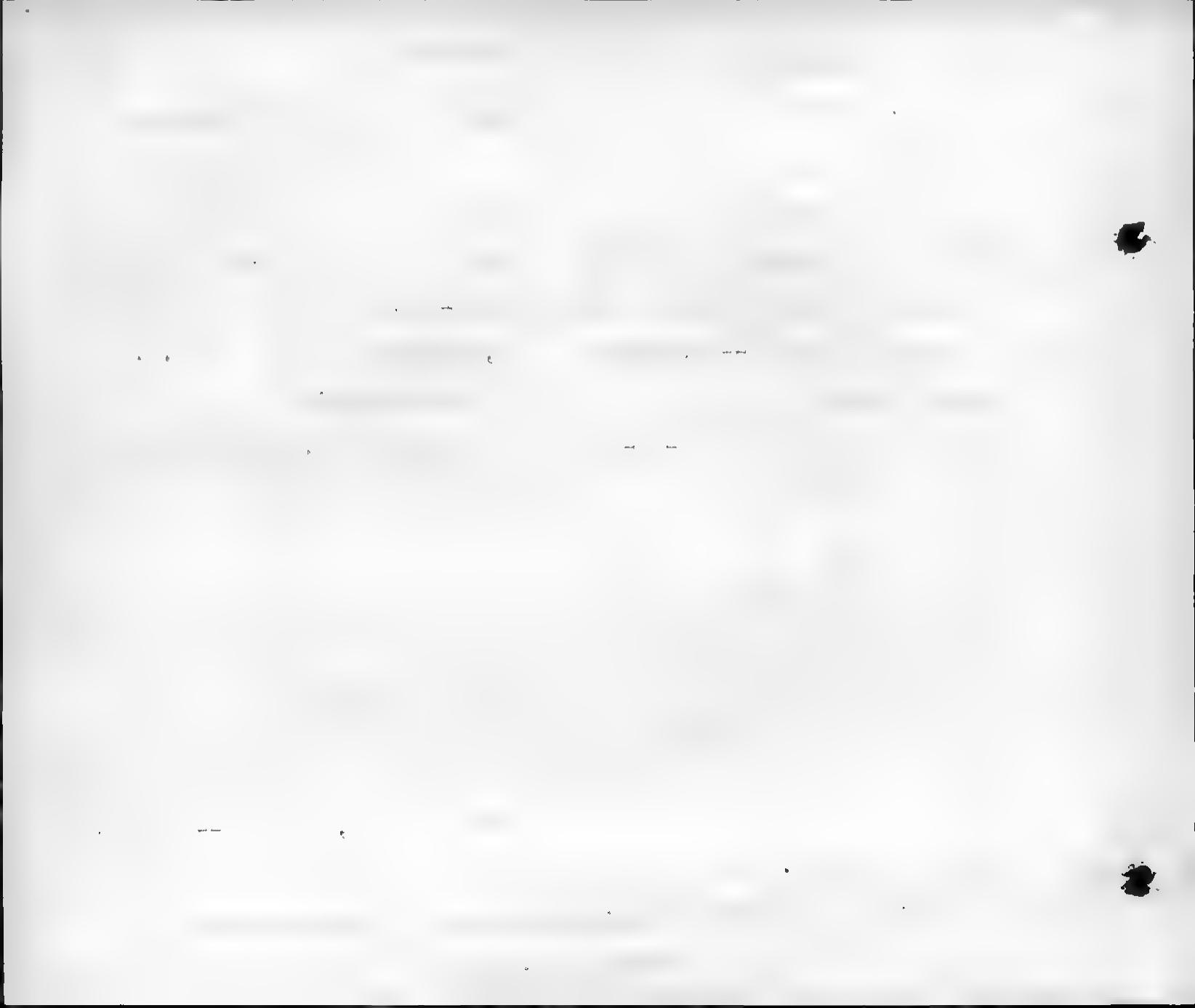
06949

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4
may be joined by the hospital or attending physician

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed fully, it may be joined by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE Maryland		b. COUNTY Montgomery		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Comus		c. LENGTH OF STAY IN 1b 50 yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Comus		d. STREET ADDRESS		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First Thomas	Middle Wilfred	Last Brown	4. DATE OF DEATH June 19 1958	Month June	Day 19	Year 1958
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct 24-1895		9. AGE (in years last birthday) 62 yrs	IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired merchant-Groceries		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY U.S.		
13. FATHER'S NAME Thomas Brown		14. MOTHER'S MAIDEN NAME Albena Kendiz						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service)		16. SOCIAL SECURITY NO		17. INFORMANT 218-34-7258 Mrs Thomas Brown, Comus Maryland		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 334X		Bronchial Pneumonia		INTERVAL BETWEEN ONSET AND DEATH 3 days				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: (b) DUE TO (c) DUE TO		Cerebral Softening with paralysis + convulsions		3 years				
		Cerebral Arteriosclerosis		5 years				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (b)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> TO CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from 27 Aug 1951 to 19 June 1958 , that I last saw the deceased alive on 19 June 1958 , and that death occurred at 4:30 P.M. from the causes and on the date stated above				ADDRESS (Street, city or town, state)		DATE SIGNED		
ACTUAL SIGNATURE <i>Gordon M. Smith</i>		M.D.		Barnesville, Maryland - 6/20/58				
PHYSICIAN'S NAME (Type) Gordon M. Smith								
22a. BURIAL CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/21/58		22c. NAME OF CEMETERY OR CREMATORIUM Frederick Memorial		22d. LOCATION (City, town, or county) (State) Frederick, Md		
23. FUNERAL DIRECTOR'S SIGNATURE <i>William B. Helton</i>		ADDRESS Barnesville, Md		24a. REC'D BY REGISTRAR DATE JUN 23 1958		24b. REGISTRAR'S SIGNATURE <i>John C. Smith</i>		



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06950

6983

CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		c. LENGTH OF STAY IN 1b <i>3 hours</i>	
d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) e. STREET ADDRESS <i>Suburban</i>		f. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rockville</i>	
g. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Suburban</i>		h. STREET ADDRESS <i>1127 Grandin Ave.</i>	
i. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>John S. Burke</i>		4. DATE OF DEATH Month <i>6</i> Day <i>6</i> Year <i>1958</i>	
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Nov. 1, 1911</i>	
9. AGE (In years last birthday) <i>46 yrs.</i>		10. IF UNDER 1 YEAR Months <i>7</i> Days <i>5</i> Hours <i>3 hr.</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Cartographer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Army Map Service</i>	
10c. BIRTHPLACE (State or foreign country) <i>New York</i>		11. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Albert Burke</i>		14. MOTHER'S MAIDEN NAME <i>Bridget Caulfield</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>067-05-8600</i>	
17. INFORMANT <i>Rita J. Burke</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Intracerebral hemorrhage, right hemisphere</i>	
DUE TO <i>IX</i>		INTERVAL BETWEEN ONSET AND DEATH <i>3 hr.</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 19.)	
20c. TIME OF INJURY Month, Day Year Hour o. m. <i>19</i> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <i>Rockville</i> (County) <i>Maryland</i> (State) <i>Md.</i>	
21. I certify that I attended the deceased from <i>May 16, 1958</i> to <i>June 6, 1958</i> , that I last saw the deceased alive on <i>June 6, 1958</i> , and that death occurred at <i>6 P.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>G. Bonditch Hunter, Jr. M.D.</i>		ADDRESS (Street, city or town, state) <i>809 Viers Mill Rd., Rockville, Md.</i> DATE SIGNED <i>6/7/1958</i>	
PHYSICIAN'S NAME (Type) <i>G. Bonditch Hunter, Jr. M.D.</i>		22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> 22b. DATE THEREOF <i>6/10/1958</i> 22c. NAME OF CEMETERY OR CREMATORIUM <i>Parklawn</i> 22d. LOCATION (City, town, or county) <i>Rockville</i> (State) <i>Maryland</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert A. Pumphrey-7557 Wis. Ave. Beth. Md.</i>		24a. REC'D BY REGISTRAR DATE <i>JUN 10 1958</i> 24b. REGISTRAR'S SIGNATURE <i>G. Bonditch</i>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06951

6960

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Maryland		b. COUNTY Montgomery		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville		c. LENGTH OF STAY IN lb 100 North Grandin Avenue		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville		d. STREET ADDRESS 100 North Grandin Avenue		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 100 North Grandin Avenue				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Annie E. Bullock		First	Middle	Last	4. DATE OF DEATH June 17 1958	Month	Day	Year
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/>	B. DATE OF BIRTH 5/27/1902	9. AGE (In years lost birthday) 50 yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months 20 Days 0 Hours 0 Min 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY US		
13. FATHER'S NAME Pat Connelly		14. MOTHER'S MAIDEN NAME Annie Hendy						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Catherine Elliott-Brown		Address Daughter Island, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		<i>Adeno carcinoma of rectum</i>				INTERVAL BETWEEN ONSET AND DEATH 26 mos.		
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first (b)		DUE TO						
		DUE TO						
		(c)						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) —						
20c. TIME OF INJURY Hour o. m. 1 p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —		20f. (City or town) —		(County) — (State) —
21. I certify that I attended the deceased from October 1958 to 6/17 1958 , that I last saw the deceased alive on 6/17 1958 , and that death occurred at 12:10 AM from the causes and on the date stated above						ADDRESS (Street, city or town, state) 41 W. Wood Lane, Rockville, Md.		DATE SIGNED 6/17/58
ACTUAL SIGNATURE <i>Arthur F. Woodward</i>								
PHYSICIAN'S NAME (Type) Arthur F. Woodward		41 W. Wood Lane, Rockville, Md.						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/19/58		22c. NAME OF CEMETERY OR CREMATORIUM Darnestown Cemetery		22d. LOCATION (City, town, or county) Darnestown, Maryland		(State)
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		ADDRESS Bethesda, Maryland		24a. REC'D BY REGISTRAR JUN 18 '58		24b. REGISTRAR'S SIGNATURE <i>John E. Smith</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be signed by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6984

CERTIFICATE OF DEATH

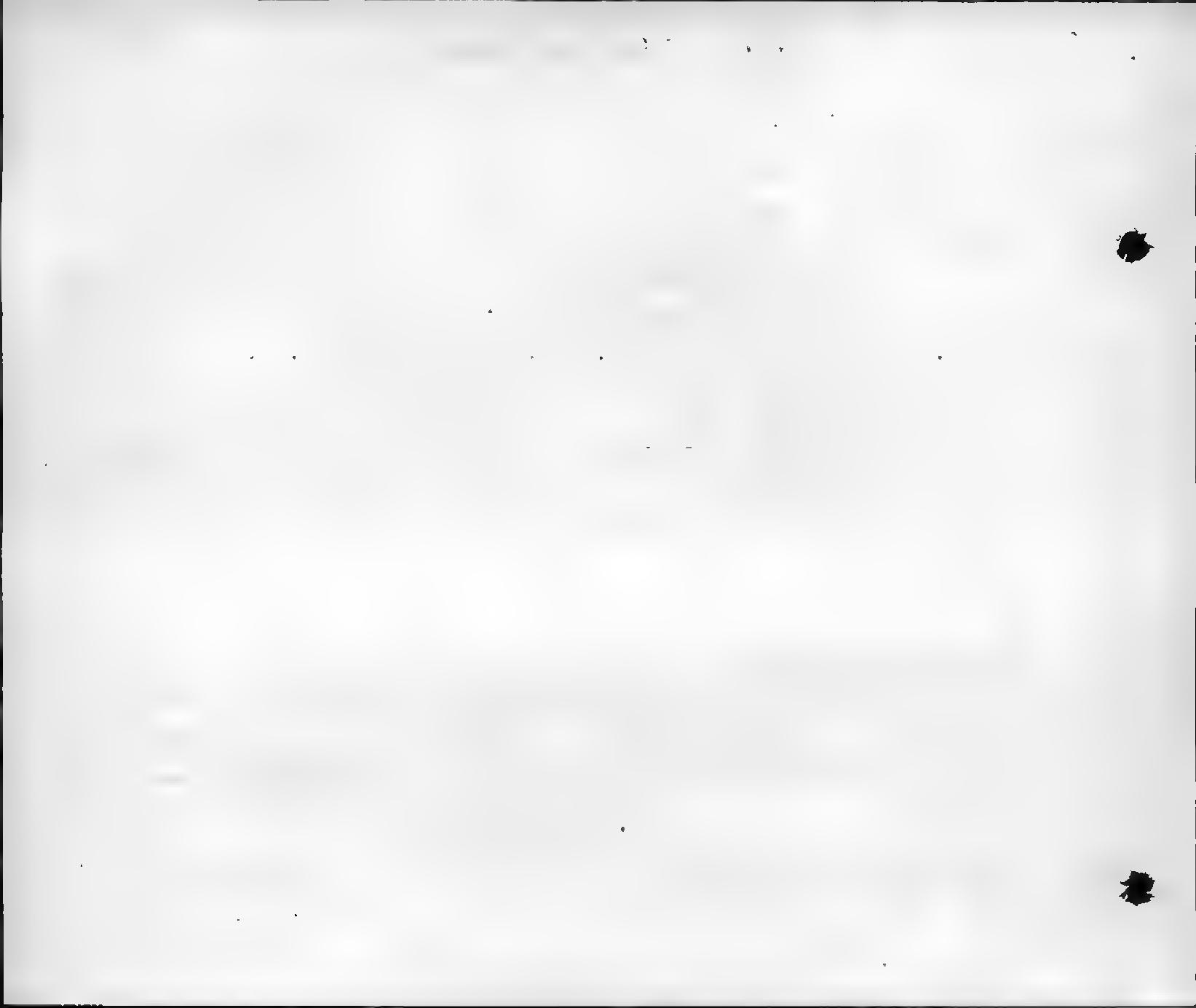
Reg. Dist. No.

06952

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE Maryland		b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 9700 Bellevue Drive		d. STREET ADDRESS 9700 Bellevue Drive		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First ELIJAH	Middle Larmer	Last BVR	4. DATE OF DEATH June 3	Month	Day	Year 1958
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH Dec. 27, 1875	9. AGE (In years last birthday) 82 yrs	IF UNDER 1 YEAR 5 Months	IF UNDER 24 HRS 6 Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Life.		10b. KIND OF BUSINESS OR INDUSTRY Draperies, etc.		11. BIRTHPLACE (State or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME Richard Moore Burton		14. MOTHER'S MAIDEN NAME Mary Creighton					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or date of service) No		16. SOCIAL SECURITY NO. 577-48-7505A		17. INFORMANT Mrs. Geo. Caldwell - same as 2d		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. } DUE TO (b) DUE TO (c)		Cancer, Cancer, Cancer		INTERVAL BETWEEN ONSET AND DEATH 30 mo			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) olive oil					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Kensington, Maryland		20f. (City or town) Kensington	(County) (State) Montgomery Maryland
21. I certify that I attended the deceased from _____ to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred on _____, 19____, at _____, M, from the causes and on the date stated above. ACTUAL SIGNATURE SAM ALLEN, M.D. Kensington, Maryland						ADDRESS (Street, city or town, state) Kensington, Maryland	
PHYSICIAN'S NAME (Type) Samuel Allen, M.D.						DATE SIGNED 1/25/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/5/58		22c. NAME OF CEMETERY OR CREMATORIUM Cedar Hill		22d. LOCATION (City, town, or county) Suitland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		ADDRESS Bethesda, Maryland		24a. REC'D BY REGISTRAR DAN 9 '58		24b. REGISTRAR'S SIGNATURE DeLoach	

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



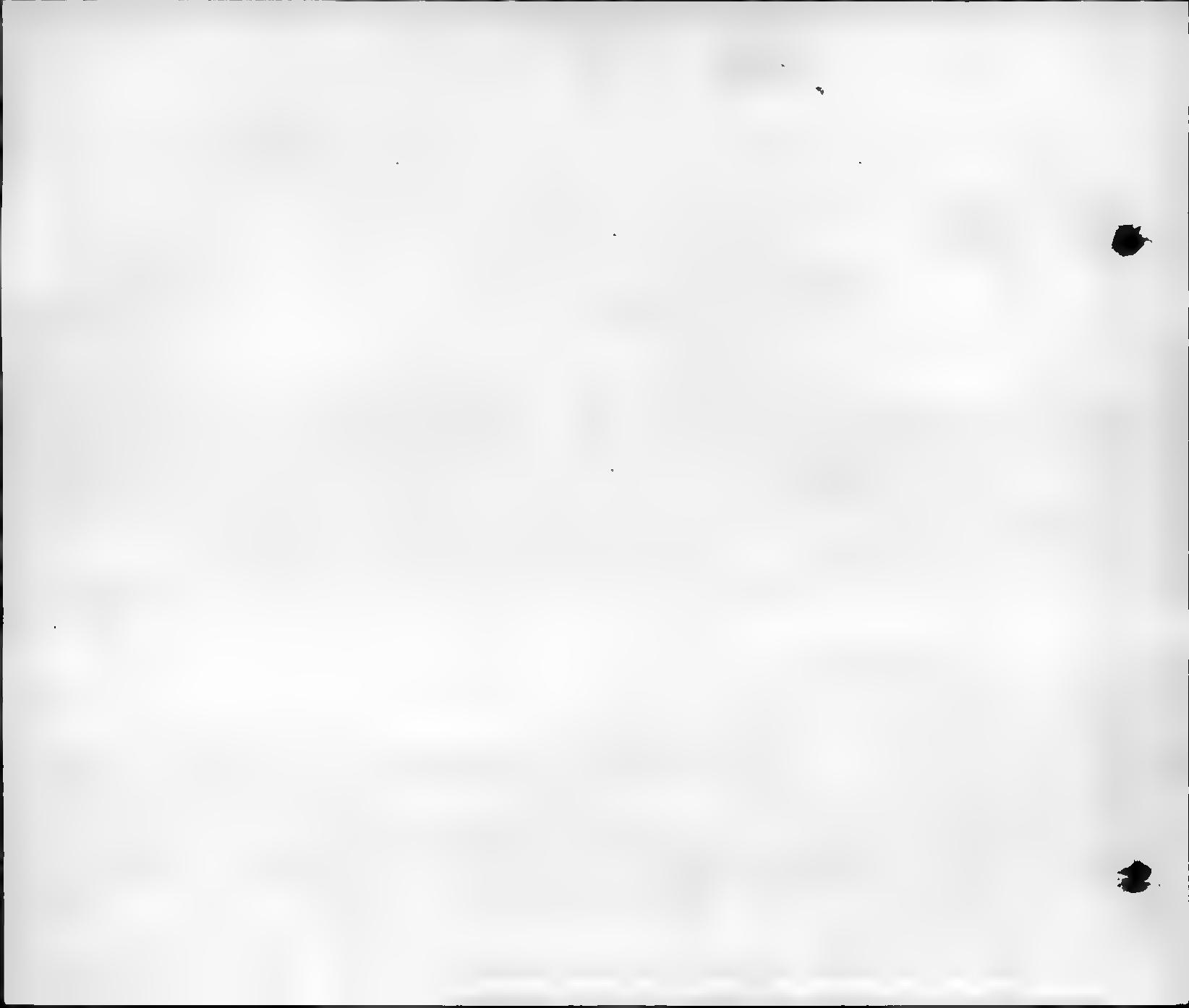
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

06953

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND b. COUNTY MONT.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK MD		c. LENGTH OF STAY IN 1b 9 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WASHINGTON SAN. & HOSP. - T.P.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WHITETON	
f. FIRST NAME ORA MIDDLE GALEN LAST CARNES		g. DATE OF DEATH 6 Month JUNE Day 19 Year 1958	
5. SEX MALE COLOR OR RACE WHITE		6. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 7. B. DATE OF BIRTH 1-27-84	
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. AGE (In years lost birthday) 74 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MINISTER		10b. KIND OF BUSINESS OR INDUSTRY	
10c. BIRTHPLACE (State or foreign country) OHIO Illinois		11. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME JOHN H. CARNES		14. MOTHER'S MAIDEN NAME CAROLINE PERSON	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 17. INFORMANT HOSP. RECORDS Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 153.8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b). DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause (c). PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		INTERVAL BETWEEN ONSET AND DEATH 2 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While Not while at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 7, 1958, to June 19, 1958, that I last saw the deceased alive on June 19, 1958, and that death occurred at 10:30 AM, from the causes and on the date stated above. ACTUAL SIGNATURE MICHAEL DOBRIDGE M.D. ADDRESS (Street, city or town, state) 10620 ECRAS-4 Ave. Silver Spring, Md. DATE SIGNED June 19, 1958			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 23, 1958	
22c. NAME OF CEMETERY OR CREMATORIAL Parklawn Cemetery		22d. LOCATION (City, town, or county) (State) Montgomery County, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE G. Arthur Wallis, 254 Carroll St N.W. N.C.		24a. REC'D BY REGISTRAR ADDRESS DATE JUN 20 1958	
		24b. REGISTRAR'S SIGNATURE	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06954

6985

CERTIFICATE OF DEATH

Reg. Dist. No. 215

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, by the funeral director,
page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Virginia		b. COUNTY					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 32 hr. 20 min.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Alexandria							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.		d. STREET ADDRESS 23040 King Highway		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print)	First Thomas	Middle Homer	Last CARR	4. DATE OF DEATH June 7 1958	Month Year	Day	Year				
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 6-6-58	9. AGE (In years lost birthday) yrs 7	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days	Hours	Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY U.S.					
13. FATHER'S NAME Homer Judson CARR				14. MOTHER'S MAIDEN NAME Shirley Louise HALL							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT (Father) Homer J. Carr (Same As #2)		Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Anemia DUE TO 773.5								INTERVAL BETWEEN ONSET AND DEATH 32 hours			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)		DUE TO (c)		(b) Styphline Membraenia + Prematurity 32 hours							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART (a)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) U.S. Naval Hospital, Bethesda, Md.		(County)	(State)		
21. I certify that I attended the deceased from 6-6-1958 to 6-7-1958 , that I last saw the deceased alive on 7 June 1958 , and that death occurred at 10:00A.M. from the causes and on the date stated above										ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md.	DATE SIGNED 6-7-58
ACTUAL SIGNATURE 		M.D.									
PHYSICIAN'S NAME (Type) J. C. PARKE, JR., LT, MC, USN		U.S. Naval Hospital, Bethesda, Md.									
22a. BURIAL, CREMAT. ON, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-11-58		22c. NAME OF CEMETERY OR CREMATORIUM		22d. LOCATION (City, town, or county) Harrisonburg, Penna.		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE 		ADDRESS R.A. Pumfrey, 1357 Wisconsin Ave., Bethesda, Md.		24a. REC'D BY REGISTRAR MIN 10 '58		24b. REGISTRAR'S SIGNATURE 					



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

06955

Reg. Dist. No.

6941

1. PLACE OF DEATH

a. COUNTY

Montgomery

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Takoma Park

c. LENGTH OF STAY IN 1b
OR INSTITUTION

6 days

d. NAME OF HOSPITAL (If not in hospital, give street address)

OR INSTITUTION

Washington Sanitarium + Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)

a. STATE

Maryland

b. COUNTY

Montgomery

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

d. STREET ADDRESS

505 Domer Ave.

e. IS RESIDENCE
ON A FARM?
YES NO 3. NAME OF
DECEASED
(Type or print)

First

Middle

Last

4. DATE
OF
DEATH

Month

Doy

Year

June

30

1958

5. SEX

Female

6. COLOR OR RACE

W.

7. MARRIED NEVER MARRIED WIDOWED DIVORCED

8. DATE OF BIRTH

3-6-98

9. AGE (In years
lost birthday)

60 yrs

10. IF UNDER 1 YEAR

Months Days Hours Min

10a. US LAB OCCUPATION (Give kind of work done
during most of working life, even if retired)

Housewife

10b. KIND OF BUSINESS OR INDUSTRY

Own home

11. BIRTHPLACE (State or foreign country)

Pa.

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Arthur C. Eckert

14. MOTHER'S MAIDEN NAME

Anna Roth

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes no or unknown)

No

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO

Yes

17. INFORMANT

Patient

Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

440.1

DUE TO

Conditions, if any, which
gave rise to immediate
cause (a), stating the under-
lying cause (if any)

Barcorary Occlusion

INTERVAL BETWEEN
ONSET AND DEATH

6 mos

(b)

Arteriosclerosis

3 years

DUE TO

Pulmonary Infarcts

2 days

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY
PERFORMED?YES NO

X

X

X

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH
(If either, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day, Year
Hour o. m.
p. m.20d. INJURY OCCURRED
While
of work Not while
at work 20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

A.M.

21. I certify that I attended the deceased from January 1, 1955, to July 2, 1958, that I last saw the deceased
alive on July 30, 1958, and that death occurred at 10305th, from the causes and on the date stated above.

ADDRESS (Street, city or town, state) DATE SIGNED

ACTUAL
SIGNATURE

Robert A. Hare M.D. 809 Davis Ave., T.P. Md. 63058

PHYSICIAN'S
NAME (Type)

Robert A. Hare 809 Davis Ave., T.P. Md. 63058

22a. BURIAL CREMATION,
REMOVAL (Specify)
BURIAL

22b. DATE THEREOF

7/2/58

22c. NAME OF CEMETERY OR CREMATORIUM

MT. OLIVET CEMETERY

22d. LOCATION (City, town, or county)

HANOVER, PENNSYLVANIA

(State)

23. FUNERAL DIRECTOR'S SIGNATURE

Warren G. Humphrey, SILVER SPRING, MD.

24a. REC'D BY REGISTRAR

JUL 2 '58

DATE

24b. REGISTRAR'S SIGNATURE

A. Smith

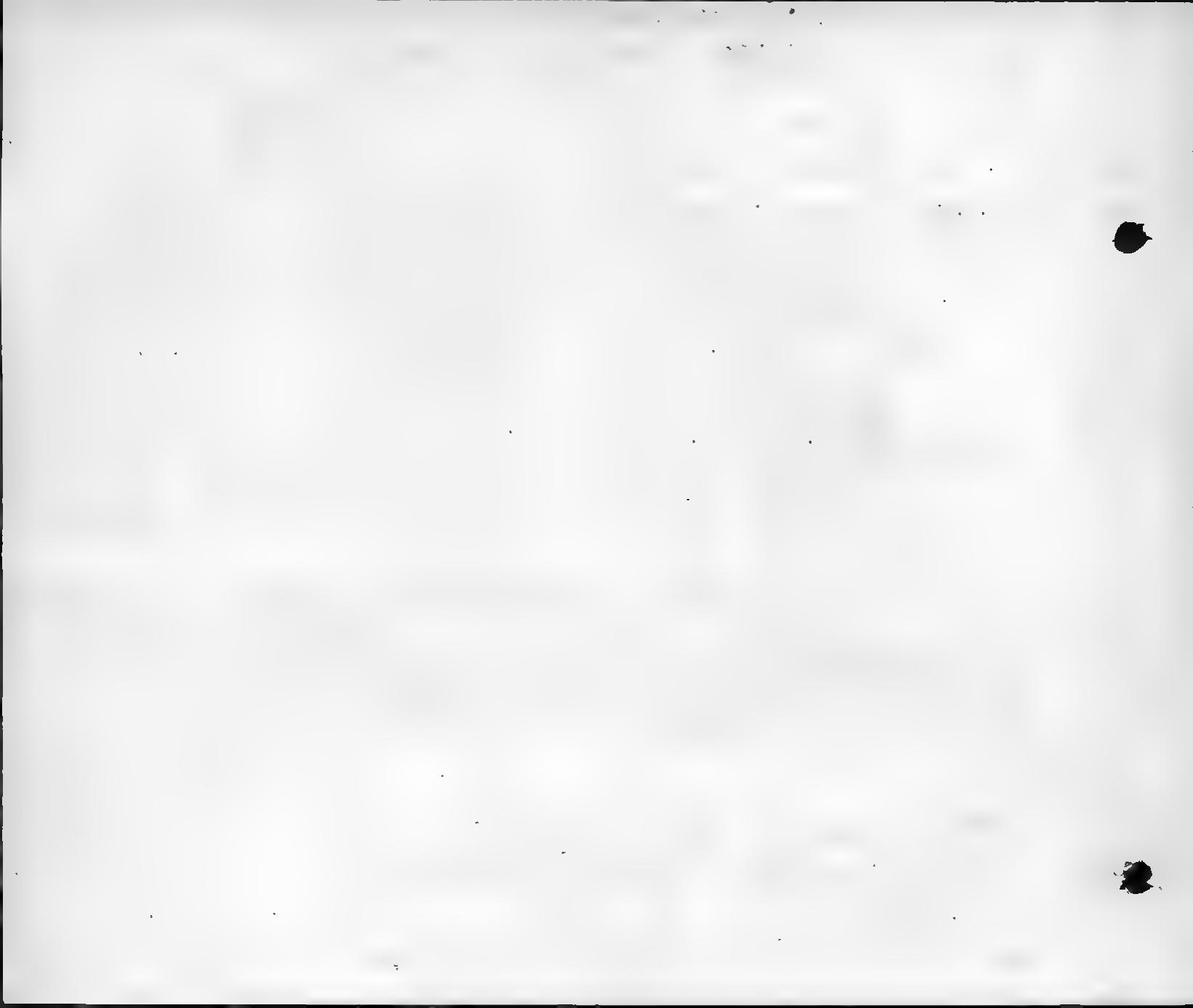
15



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4

may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director,
page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										06956		
6986 CERTIFICATE OF DEATH										Reg. Dist. No. 215		
1. PLACE OF DEATH a. COUNTY		Montgomery MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)		d. STATE Virginia b. COUNTY Fairfax					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)					c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)					
Bethesda (Rural)					39 days		Alexandria					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		U.S. Naval Hospital, Bethesda, Md.			d STREET ADDRESS		141 No. Grayson Street			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First Thomas		Middle Spearman	Last COATS	4. DATE OF DEATH	June	Month	Day	Year	13	19 58
5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years (last birthday) 41 yrs	IF UNDER 1 YEAR IF UNDER 24 HRS					
Male		White		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	Oct. 13, 1916	Months Days Hours Min						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)			12. CITIZEN OF WHAT COUNTRY					
Mariner		U. S. Navy		Louisiana			U. S. A.					
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME							
Lewis Leavell COATS					Clyde SPEARMAN							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) Yes		16. SOCIAL SECURITY NO		17. INFORMANT		Address						
(If yes, give war or date of service) WWII -Korean		570-20-1484		(W) Elmay J. Coats, same as #2								
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]												
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Bile duct carcinoma with extensive hepatic metastasis</i>												
DUE TO <i>10 months</i>												
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b)												
DUE TO (c)												
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)										
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)		
19 May 6, 1958												
21. I certify that I attended the deceased from May 6, 1958, to June 13, 1958, that I last saw the deceased alive on June 13, 1958, and that death occurred at 6:47 P.M., from the causes and on the date stated above.												
ADDRESS (Street, city or town, state) MD U. S. Naval Hospital, NNMC DATE SIGNED 6-14-58												
ACTUAL SIGNATURE <i>R. P. DOBBIE, JR.</i>												
PHYSICIAN'S NAME (Type)		R. P. DOBBIE, JR., CDR, MC, USN Bethesda, Maryland										
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-18-58		22c. NAME OF CEMETERY OR CREMATORIUM Arlington National		22d. LOCATION (City, town, or county) Arlington		(State) Virginia				
23. FUNERAL DIRECTOR'S SIGNATURE Démaine Funeral Home, 520 So. Washington St.		ADDRESS Alexandria, Va.		24a. REC'D BY REGISTRAR DATE 20 JUN 58		24b. REGISTRAR'S SIGNATURE <i>C. J. C.</i>						
VS A15 (4) ISM 10/57												



M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

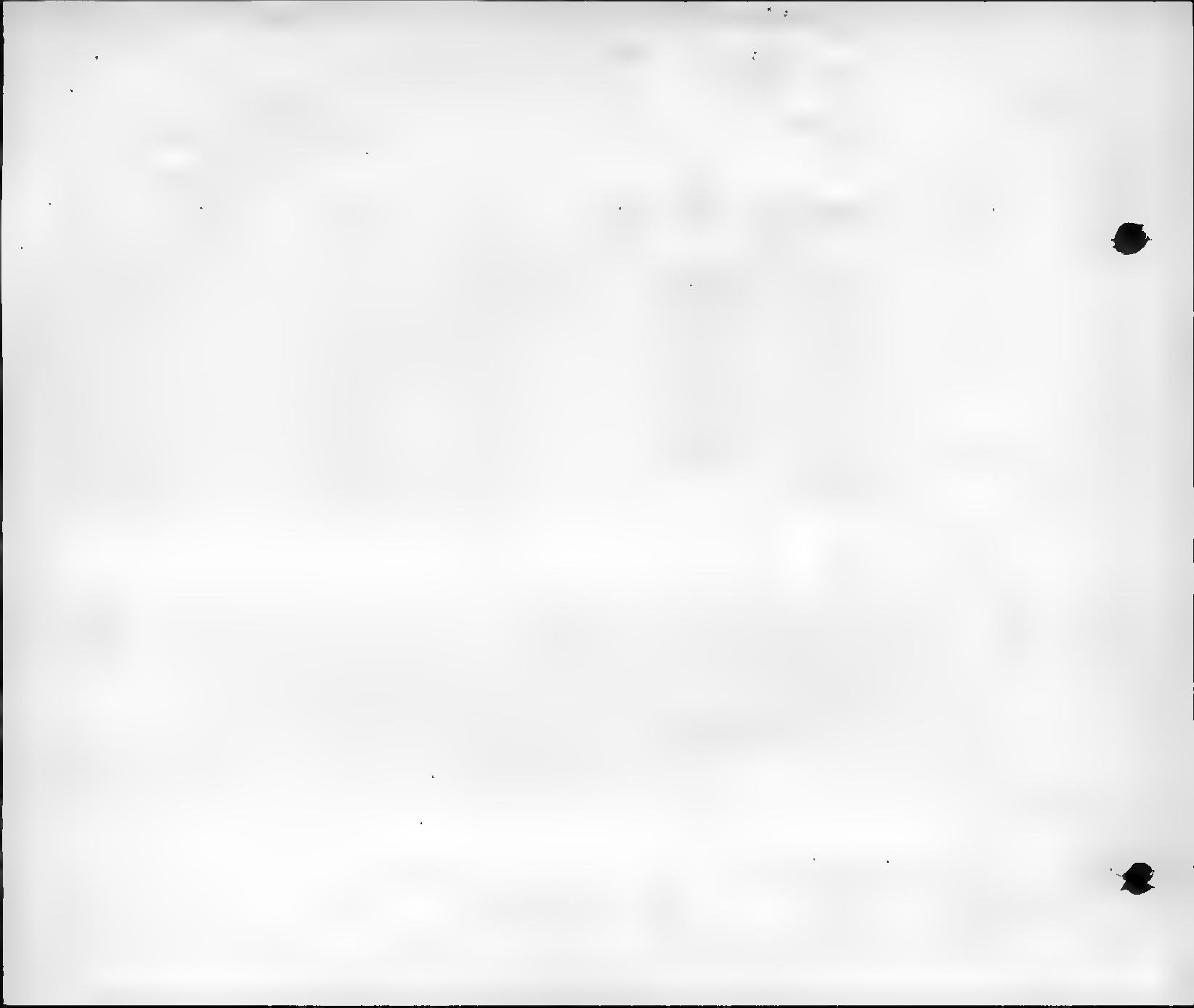
6987

CERTIFICATE OF DEATH

06957
215

Reg. Dist. No.

1. PLACE OF DEATH o COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) o. STATE District of Columbia	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN lb 31		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.		d. STREET ADDRESS 3101 Sherman Ave., N.W.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Pauline	Middle Edward	Last COLEMAN	4. DATE OF DEATH June 19	Month Year Day 19 58
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH January 4, 1911	9. AGE (In years last birthday) 47 yrs	IF UNDER 1 YEAR Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Housewife		11. BIRTHPLACE (State or foreign country) Virginia	
13. FATHER'S NAME Edward Brown		14. MOTHER'S MAIDEN NAME Lily Campbell		12. CITIZEN OF WHAT COUNTRY U.S.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Official Navy Records	
Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 6000.0 DUE TO Chronic Pyelonephritis INTERVAL BETWEEN ONSET AND DEATH 6 mos.					
Conditions, if any which gave rise to immediate cause (a), stating the under- lying cause last. (b)		DUE TO Chronic Pyelonephritis			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 19 May 1958, to 19 June 1958, that I last saw the deceased alive on 19 June 1958, and that death occurred at 11:30A.M., from the causes and on the date stated above ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md. 6-20-58 DATE SIGNED					
ACTUAL SIGNATURE 					
PHYSICIAN'S NAME (Type) R.G. Muth, LT, MC, USN		U.S. Naval Hospital, Bethesda, Md.			
22a. BURIAL CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-24-58		22c. NAME OF CEMETERY OR CREMATORIAL Family Cemetery	
22d. LOCATION (City, town or county) Broad Run, Virginia		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE 		ADDRESS Joynes Funeral Home, 116 Mass Ave., Wash.D.C.		24a. REC'D BY REGISTRAR DATE JUN 24 '58	
				24b. REGISTRAR'S SIGNATURE 	



1

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enter the certificate, writing the word "Pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be used for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-tentorial permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Film G231 7/21/58 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06958

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY

6942

MARYLAND

b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town)

Montgomery

c. LENGTH OF STAY IN TB

3 mo

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Fair Hill Nursing Home

3. NAME OF
DECEASED
(Type or print)

First Middle

Bessie R. Coroner

5. SEX

6. COLOR OR RACE

7. MARRIED

NEVER MARRIED

DIVORCED

WIDOWED

8. DATE OF BIRTH

1882

9. AGE

In years

100 days

100 months

Last birth day

75 th

75 yrs

75 months

Month

June

25

Day

1958

Year

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

13. FATHER'S NAME

Leroy K. Campbell

14. MOTHER'S MAIDEN NAME

Sophia Dabnick

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)

16. SOCIAL SECURITY NO.

17. INFORMANT

Nursing Home Record

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

4:20 P.M.

DUE TO

Coroner's occlusion

INTERVAL BETWEEN
ONSET AND DEATH

sudden

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

(b)

DUE TO

Hypertension

years

(c)

DUE TO

U. A.

1 yr

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) 19. WAS AN AUTOPSY
PERFORMED? YES NO

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS
PRIMARY or CONTRIBUTING CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18)

20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m.20d. INJURY OCCURRED
While at work Not while at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)
(County) (State)21. I certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry , and in my opinion death resulted from: Natural causes Accident , Suicide , Homicide , Undetermined manner ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)EXAMINER'S
NAME (Type)220. BURIAL CREMATION,
REMOVAL (Specify)

221. DATE THEREOF

222. NAME OF CEMETERY OR CREMATORIUM

223. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

24a. REC'D BY REGISTRAR
DATE JUN 27 '58

24b. REGISTRAR'S SIGNATURE

DATE

M.D. CHIEF MEDICAL EXAMINER ASSISTANT MEDICAL EXAMINER DEPUTY MEDICAL EXAMINER

DATE SIGNED

6-25-58

Marshall County, West Virginia

(State)

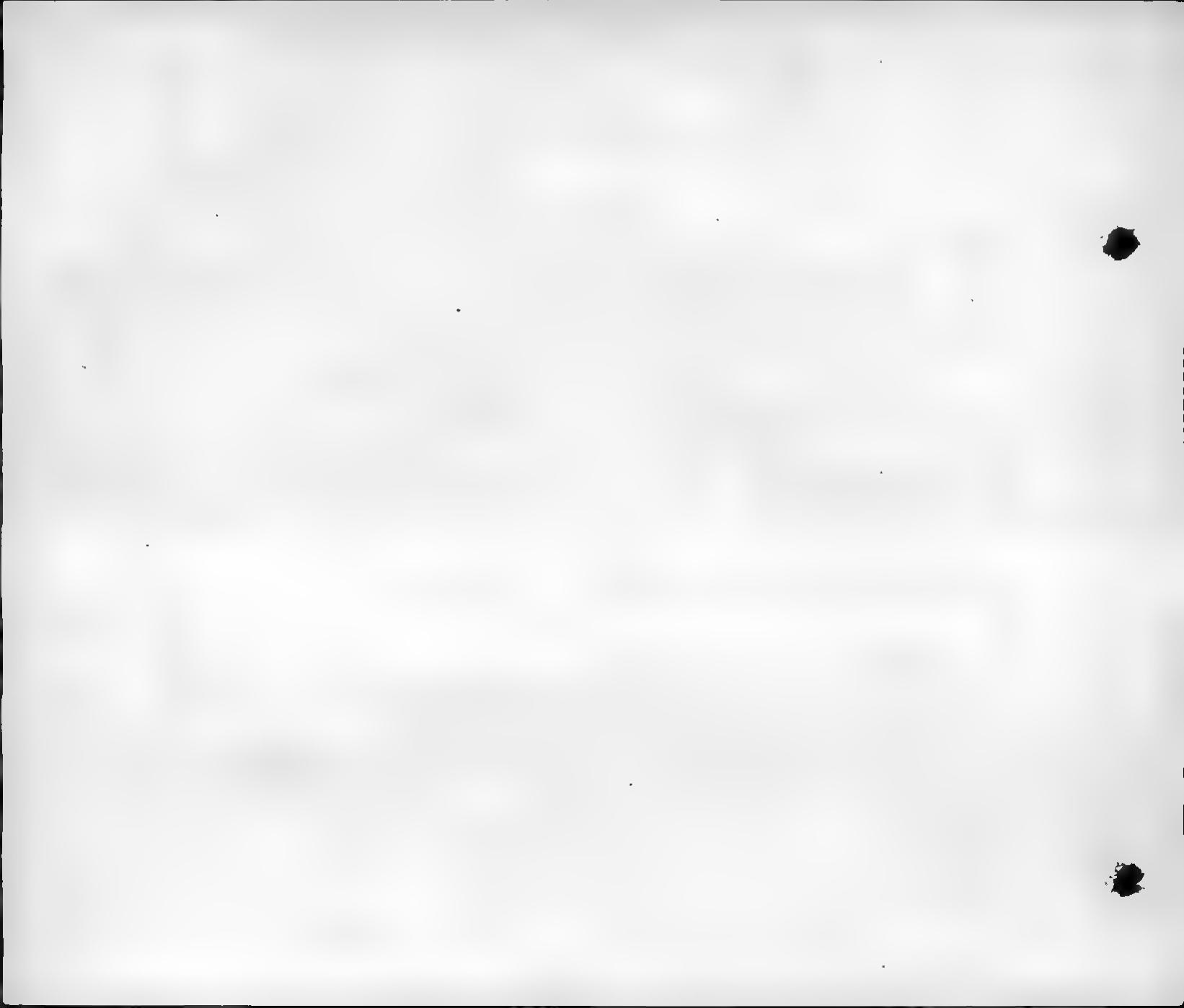
West Virginia

(State)

West Virginia

(State)

West Virginia



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

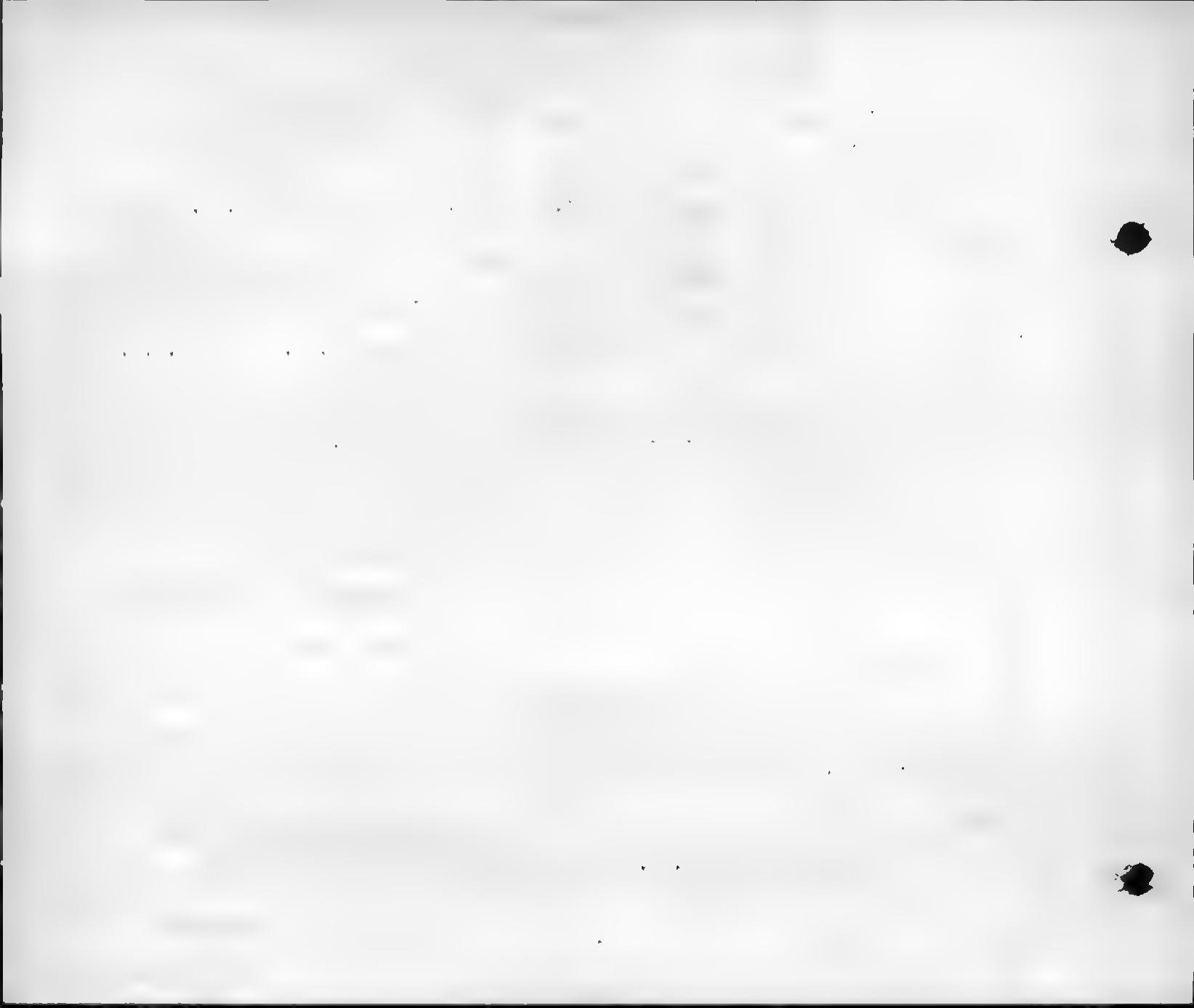
06959

6988

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o COUNTY Montgomery		MARYLAND	2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) o STATE District of Columbia	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda	c. LENGTH OF STAY IN 1b 44 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.	d. STREET ADDRESS 821 Oglethorpe Street, N. E.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Alice	Middle Patricia	Last Craven	4. DATE OF DEATH Month June Day 12, 1958
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH September 9, 1929	9. AGE (In years last birthday) 28 yrs. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Typist		10b. KIND OF BUSINESS OR INDUSTRY Insurance Office	11. BIRTHPLACE (State or foreign country) Washington, D. C.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Walter McLister		14. MOTHER'S MAIDEN NAME Lillian Robertson		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) No		16. SOCIAL SECURITY NO 577-36-0579	17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH 5 years		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)				
(c)				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from April 29, 1958, to June 12, 1958, that I last saw the deceased alive on June 12, 1958, and that death occurred at 10:10 A.M. from the causes and on the date stated above.				
ACTUAL SIGNATURE Dane R. Boggs	ADDRESS (Street, city or town, state) The Clinical Center National Institutes of Health Bethesda 14, Maryland			DATE SIGNED 6/12/58
PHYSICIAN'S NAME (Type) Dane R. Boggs, M. D.				
22a. BURIAL CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 6-16-58	22c. NAME OF CEMETERY OR CREMATORIAL Gate of Heaven	22d. LOCATION (City, town, or county) Montgomery Co. Md	(State)
22e. FUNERAL DIRECTOR'S SIGNATURE W. Hunter and Son	ADDRESS 1573 2 Ave	24a. REC'D BY REGISTRAR George	24b. REGISTRAR'S SIGNATURE Albert	DATE JUN 13 '58



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06960

6989

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN [If outside corporate limits, write RURAL and give nearest town] Scotland		2. USUAL RESIDENCE [Where deceased lived, if institution Residence before admission] a. STATE Maryland b. COUNTY Montgomery	
c. LENGTH OF STAY IN b. life		c. CITY OR TOWN [If outside corporate limits, write RURAL and give nearest town] Scotland rural	
d. NAME OF HOSPITAL [If not in hospital, give street address] OR INSTITUTION		d. STREET ADDRESS RFD Rockville	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Bertha	Middle Dove	Last Crawford
4. DATE OF DEATH	Month June	Day 24	Year 1958
5. SEX f	6. COLOR OR RACE C	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 30 1871
9. AGE [In years last birthday] 86	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0	12. IF UNDER 24 HRS Hours 0
13a. USUAL OCCUPATION [Give kind of work done during most of working life, even if retired] Housewife	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME Henry Dove		14. MOTHER'S MAIDEN NAME Mary Ann Dove	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) No		16. SOCIAL SECURITY NO. None	17. INFORMANT Eddington Crawford, Seven Locks Rd., Rockville, Md.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		Address	
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 442X		INTERVAL BETWEEN ONSET AND DEATH 2 days	
DUE TO Hypertension			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) Arteriosclerotic Cardiorenal Disease			
DUE TO Arteriosclerotic Cardiorenal Disease			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AN AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Sarcoma Bilateral Breasts Refused surgery 1950.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. [Enter nature of injury in Part I or Part II of item 18]	
20c. TIME OF INJURY Month, Day, Year Hour 6 p.m. 1958		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) RFD 1 Silver Spring, Md.
20f. (City or town) Rockville, Md.		(County) Montgomery (State) Md.	
21. I certify that I attended the deceased from Oct. 14, 1949, to June 24, 1958, that I last saw the deceased alive on June 24, 1958, and that death occurred at 6:50 P.M. , from the causes and on the date stated above.			
ACTUAL TIME Webster Sewell		ADDRESS (Street, city or town, state) RFD 1 Silver Spring, Md.	
PHYSICIAN'S NAME (Type) Webster Sewell, M.D.		DATE SIGNED Jul 7 '58	
22a. BURIAL, CREMATION, REMOVAL (Check) BURIAL	22b. DATE THEREOF 6/28/58	22c. NAME OF CEMETERY OR CREMATORIAL Lincoln Park,	22d. LOCATION (City, town, or county) Rockville, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Robert L. Bowley		24a. REC'D BY REGISTRAR Jul 7 '58	24b. REGISTRAR'S SIGNATURE Albert E. Smith

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

R. A.
D.

B

a
t

b
c

d
e

f



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06961

Item 7, Film G231, 7/16, 1958

6990

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY

Montgomery MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Bethesda Maryland

c. LENGTH OF STAY IN lb
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

Suburban

2. USUAL RESIDENCE (Where deceased lived, If institution, Residence before admission)
a. STATE b. COUNTY

Maryland Mont Co.

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Bethesda Md

d. STREET ADDRESS

10209-Tyburn Terrace

• IS RESIDENCE
ON A FARM?
YES NO 3. NAME OF
DECEASED
(Type or print)First Middle Last DATE
Grace S. Cunningham DEATH Month Day Year
Tame 28 1958

4. SEX

5. COLOR OR RACE

white

6. MARRIED NEVER MARRIED
WIDOWED DIVORCED 7. MARRIED NEVER MARRIED
WIDOWED DIVORCED

8. DATE OF BIRTH

9. AGE (in years
last birthday)
yrs.10. USUAL OCCUPATION (Give kind of work done
during most of working life, even if retired)

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DESEASER EVER IN U.S. ARMED FORCES? (Yes, no or unknown)
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO

17. INFORMANT

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

19. WAS AUTOPSY
PERFORMED?
YES NO PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)DUE TO
Conditions, if any, which
gave rise to immediate
cause (a), stating the under-
lying cause lost. (b)DUE TO
Cause, if any, which
gave rise to immediate
cause (b). (c)INTERVAL BETWEEN
ONSET AND DEATH
Two DAYS

Two DAYS.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH
(If either, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour a.m. 19
p.m.20d. INJURY OCCURRED
While Not while
of work at work 20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from June 26, 1958, to June 28, 1958, that I last saw the deceased
alive on June 28, 1958, and that death occurred at 12:55 PM, from the causes and on the date stated above.

ADDRESS (Street, city or town, state)

DATE SIGNED

ACTUAL
SIGNATUREPHYSICIAN'S
NAME (Type)

Joseph R. Connor, M.D. 9420 Old Georgetown Rd. 28 June 1958

Bethesda, Maryland

22. BURIAL/CREMATION, DATE THEREOF
REMOVAL (Specify)

22c. NAME OF CEMETERY OR CREMATORIUM

22d. LOCATION (City, town, or county)
(State)

Burial 7-2-58 Mt. Hope Cem. Chicago Ill

23. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

24a. REC'D BY REGISTRAR
DATE JUL 2 '58

24b. REGISTRAR'S SIGNATURE

Deaf Funeral Home 4812 LaSalle Ave. West DC

Abraham

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 24 hours after death.

VS A15 (4)
15M 9/55



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6991

CERTIFICATE OF DEATH

06962

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <u>Maryland</u>		b. COUNTY <u>Bethesda</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>2 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		d. STREET ADDRESS <u>4615 Hylan, Lane</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <u>Core</u>	Middle <u>G.</u>	Last <u>Currier</u>	4. DATE OF DEATH	Month <u>June</u>	Day <u>19</u>	Year <u>1958</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 5, 1888</u>	9. AGE (In years last birthday) <u>89 yrs.</u>	10. IF UNDER 1 YEAR Months <u>0</u>	11. IF UNDER 24 HRS Days <u>14</u>	12. Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Holue</u>		11. BIRTHPLACE (State or foreign country) <u>Iowa</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Gillette</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>(Son) Shirley Currier - same as 2</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>193X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO <u>Sanition</u> (c)							
INTERVAL BETWEEN ONSET AND DEATH <u>7 days.</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
19a. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Feb. 19, 1958</u> , to <u>June 19, 1958</u> , that I last saw the deceased alive on <u>June 19, 1958</u> , and that death occurred at <u>4 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>4711 Highland Ave. Bldg. 1</u>							
DATE SIGNED <u>6/20/58</u>							
ACTUAL SIGNATURE <u>Alfred S. Norton</u>							
PHYSICIAN'S NAME (Type) <u>Alfred S. Norton</u> 4711 Highland Ave. Bethesda, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/23/58</u>		22c. NAME OF CEMETERY OR CREMATORIUM <u>Parklawn Cemetery</u>		22d. LOCATION (City, town, or county) <u>Rockville, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Lumpley, Bethesda, Maryland</u>				ADDRESS <u>3 Bethesda 11, Md.</u>		24a. REC'D BY REGISTRAR <u>JUN 23 '58</u>	
						24b. REGISTRAR'S SIGNATURE <u>John J. Edwards</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 1-8, p. 1, 230, 6-12nd pt.

06963

6992

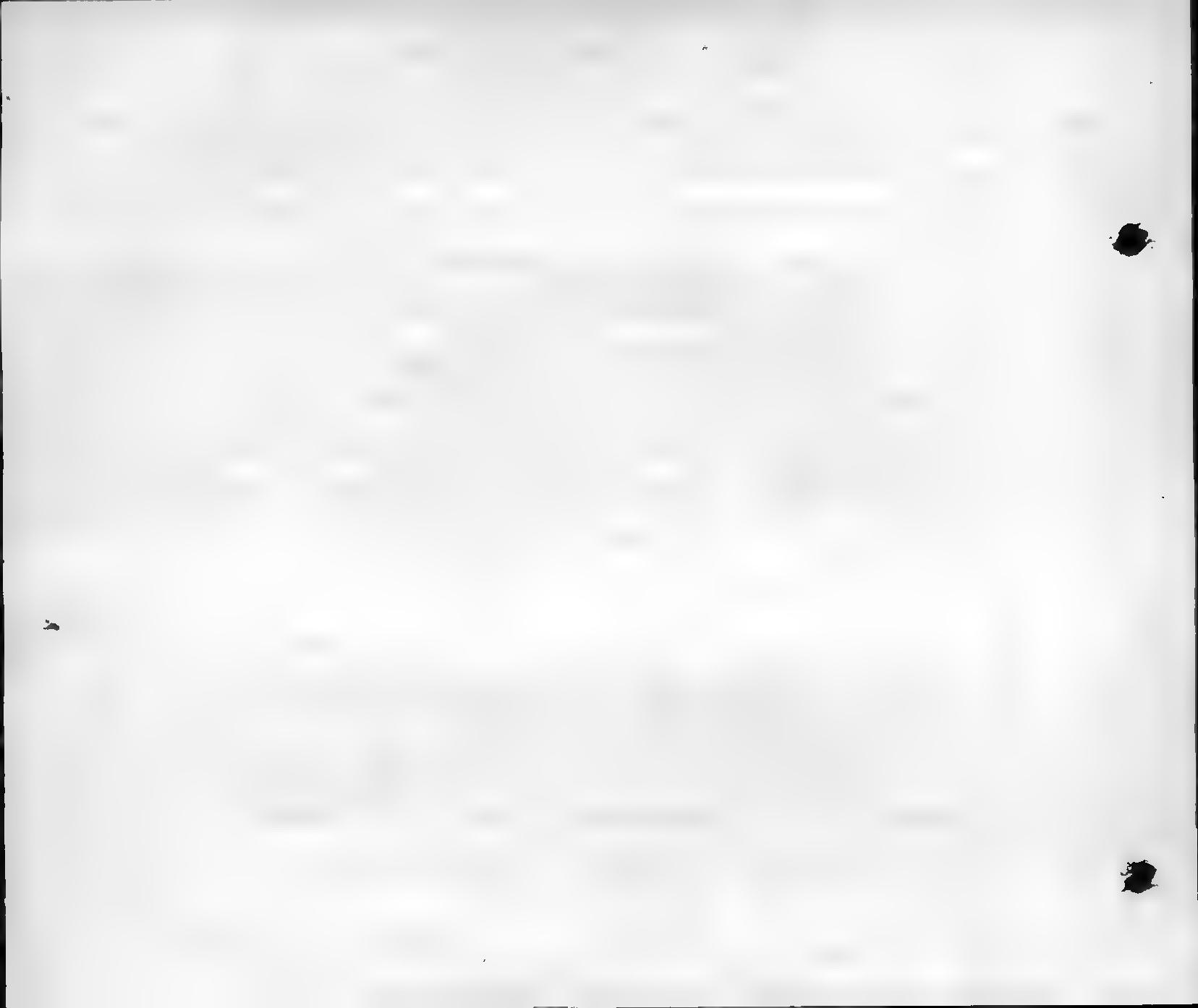
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery County</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Montgomery</i>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		LENGTH OF STAY IN 16 RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>X Chevy Chase</i>							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Alta Vista Nursing Home</i>		d. STREET ADDRESS <i>4228 Leland Street</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print)	First <i>Frank</i>	Middle <i>W</i>	Last <i>Dahn</i>	4. DATE OF DEATH <i>1880</i>	Month <i>Jan.</i>	Day <i>17</i>	Year <i>1958</i>				
5. SEX <i>Male</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <i>1880</i>	9. AGE (In years last birthday) <i>78</i>	10. IF UNDER 1 YEAR Months <i>4</i>	11. IF UNDER 24 HRS Days <i>15</i>	12. IF UNDER 24 HRS Hours <i>15</i>				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Patient Lawyer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Retired</i>		11. BIRTHPLACE (State or foreign country) <i>Iowa</i>		12. CITIZEN OF WHAT COUNTRY? <i>US.</i>					
13. FATHER'S NAME <i>August Dahn</i>				14. MOTHER'S MAIDEN NAME <i>Wilhelmina Kruger</i>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>Yes-Unknown</i>		17. INFORMANT <i>Norrine N. Dahn</i>		Address <i>same as 2d</i>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>442A</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last (b) DUE TO (c) <i>Cardio Vascular Renal Disease</i> <i>many years</i> <i>Typhoid Fever</i> <i>10 yrs</i> INTERVAL BETWEEN ONSET AND DEATH											
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>						20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Feb</i> , 19 <i>57</i> , to <i>June 2, 1958</i> , that I last saw the deceased alive on <i>June 1, 1958</i> , and that death occurred at <i>10 A.M.</i> from the causes and on the date stated above. ACTUAL SIGNATURE <i>Bradley D. Hodgkins</i> M.D. <i>4413 Bradley Lane</i> ADDRESS (Street, city or town, state) <i>Chevy Chase 15 Md</i>										DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>burial</i>		22b. DATE THEREOF <i>6/4/58</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>Monocacy Cemetery</i>		22d. LOCATION (City, town, or county) <i>Beallsville, Maryland</i>		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert A. Humphrey</i>		ADDRESS <i>Bethesda, Maryland</i>		24a. REC'D BY REGISTRAR DATE <i>JUN 4 1958</i>		24b. REGISTRAR'S SIGNATURE <i>Artie Cook</i>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove ribbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06964

Item 8, Film G-233 9/17/58.cac.

CERTIFICATE OF DEATH

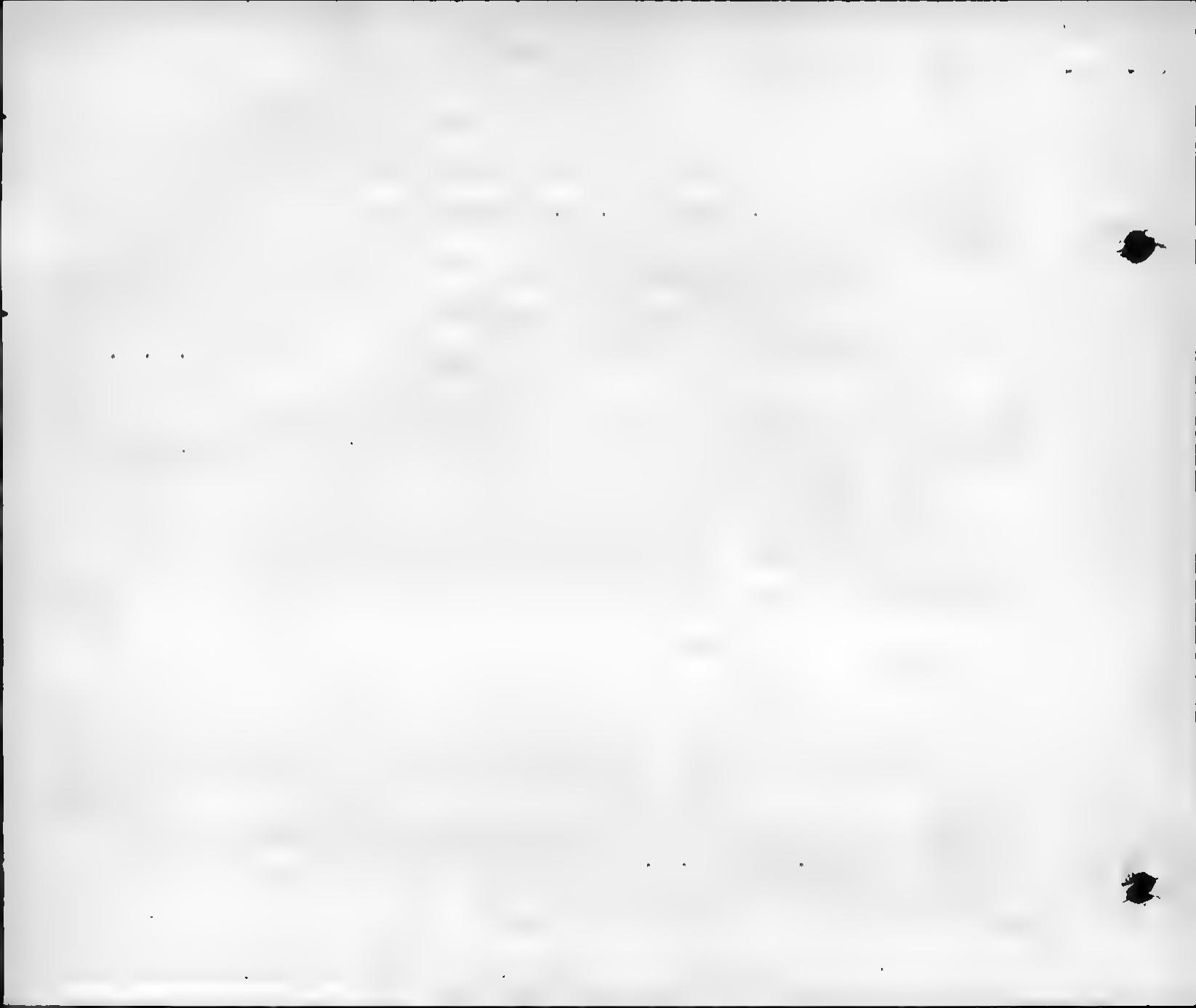
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery				2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Pennsylvania b. COUNTY				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 20 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) State College				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS 905 Walnut Street				
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
3. NAME OF DECEASED (Type or print)	First William	Middle Rotzell	Last Davey	4. DATE OF DEATH Month June	Day 15	Year 1958		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH July 22, 1921	8. AGE (In years last birthday) 36 yrs	9. IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS Days 0	Hours 0	Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) College Professor				10b. KIND OF BUSINESS OR INDUSTRY Education				
11. BIRTHPLACE (State or foreign country) Pennsylvania				12. CITIZEN OF WHAT COUNTRY? U. S. A.				
13. FATHER'S NAME Samuel Davey				14. MOTHER'S MAIDEN NAME Grace Rotzell				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) Yes		16. SOCIAL SECURITY NO. Unavailable		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 178X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				INTERVAL BETWEEN ONSET AND DEATH 2 days				
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) College	(County) Baltimore	(State) Maryland
21. I certify that I attended the deceased from May 26, 1958 to June 15, 1958 , that I last saw the deceased alive on June 15, 1958 , and that death occurred at 9:55 AM , from the causes and on the date stated above.				ADDRESS (Street, city or town, state) The Clinical Center				DATE SIGNED 6-15-58
ACTUAL SIGNATURE <i>Edward W. Moore</i>				The National Institutes of Health Bethesda 14, Maryland				
22a. BURIAL CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/17/58		22c. NAME OF CEMETERY OR CREMATORIUM Center County Memorial Park		22d. LOCATION (City, town, or county) Township, Pennsylvania		(State) Pennsylvania
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Maryland				ADDRESS Park		24a. REC'D BY REGISTRAR June 18 '58	24b. REGISTRAR'S SIGNATURE <i>Alfred Smith</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 7 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06965

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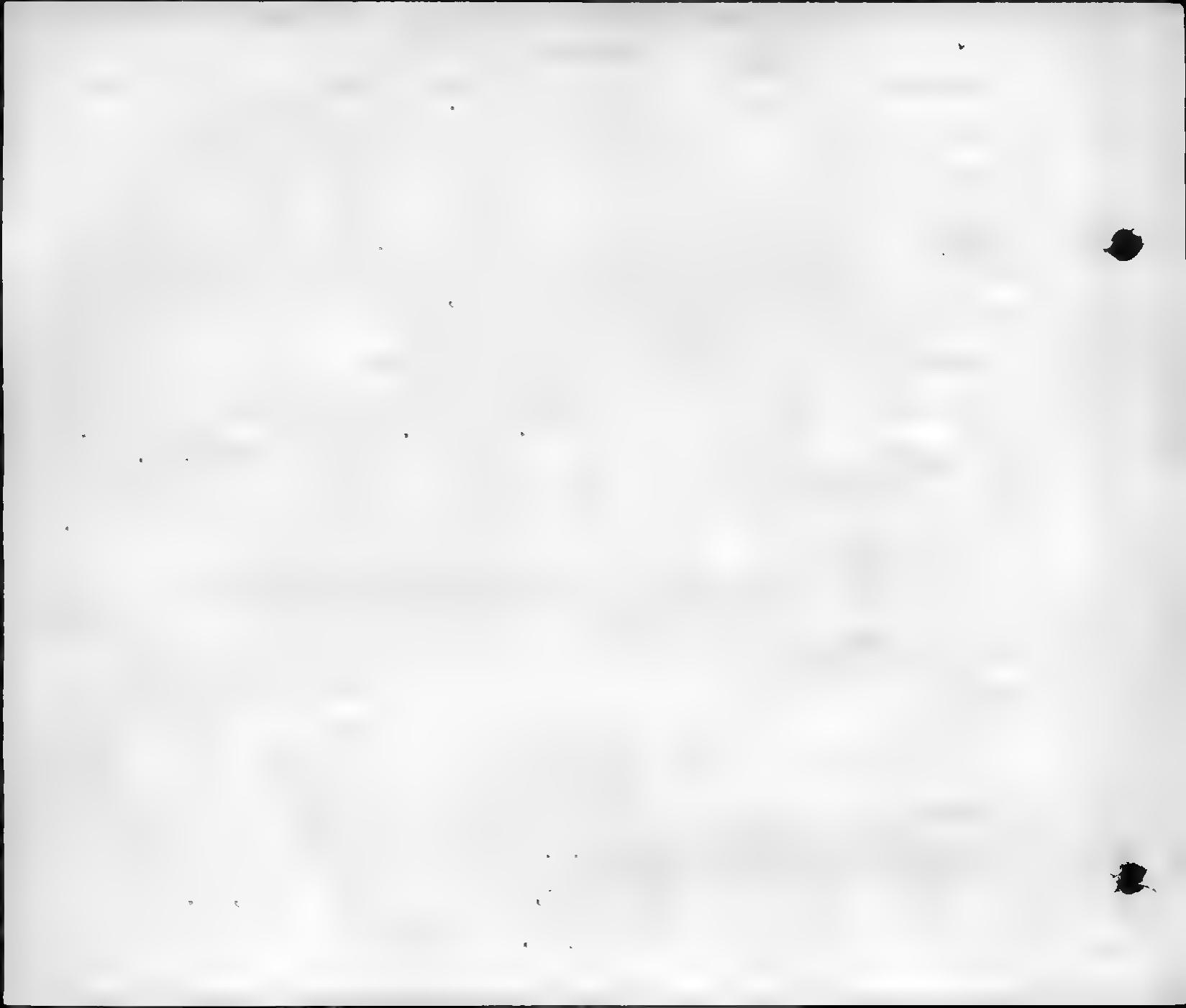
CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived - If institution, residence before admission) a. STATE N.Y.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington		c. LENGTH OF STAY IN 1b 4 mos	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Private home		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elmira	
3. NAME OF DECEASED (Type or print) Charles Henry Davis, Sr.		4. DATE OF DEATH Lost June 9 1958	
5. SEX male		6. COLOR OR RACE C	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH March 1, 1859	
WIDOWED <input type="checkbox"/>		DIVORCED <input type="checkbox"/>	
9. AGE (In years lost birthday) 69		10. IF UNDER 1 YEAR Months 0 Days 0	
		11. IF UNDER 24 HRS Hours 0 Min 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Electric Co.	
10c. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? Kensington, Md.	
13. FATHER'S NAME Joseph Davis		14. MOTHER'S MAIDEN NAME Josephine Warfield	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 17. INFORMANT Mrs. Carrie L. Davis	
		Address 4021 Plyers Mill Rd.,	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a)		19. INTERVAL BETWEEN ONSET AND DEATH 7 days	
442 X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last		Coma Acidosis	
(b)		DUE TO Hemiplegia Cerrebral Thrombosis	
(c)		DUE TO Arteriosclerosis Cardiorenal Disease	
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour e. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____ alive on _____, and that death occurred at _____, M., from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Webster Sewell, M.D., Webster Rd., Silver Spring 6/1088	
ACTUAL SIGNATURE Webster Sewell		DATE SIGNED 6/10/58	
PHYSICIAN'S NAME (Type) Webster Sewell, M.D.			
22a. BURIAL, CREMATION, OR DISPOSAL (Specify) Burial		22b. DATE THEREOF 6/12/58	
22c. NAME OF CEMETERY OR CREMATORIAL Ash Memorial		22d. LOCATION (City, town or county) (State) Sandy Spring, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert L. Snowden		24a. ADDRESS Rockville, Md.	
		24b. REC'D BY REGISTRAR DATE JUN 16 '58	
		24b. REGISTRAR'S SIGNATURE Asaf	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

66966

6994

CERTIFICATE OF DEATH

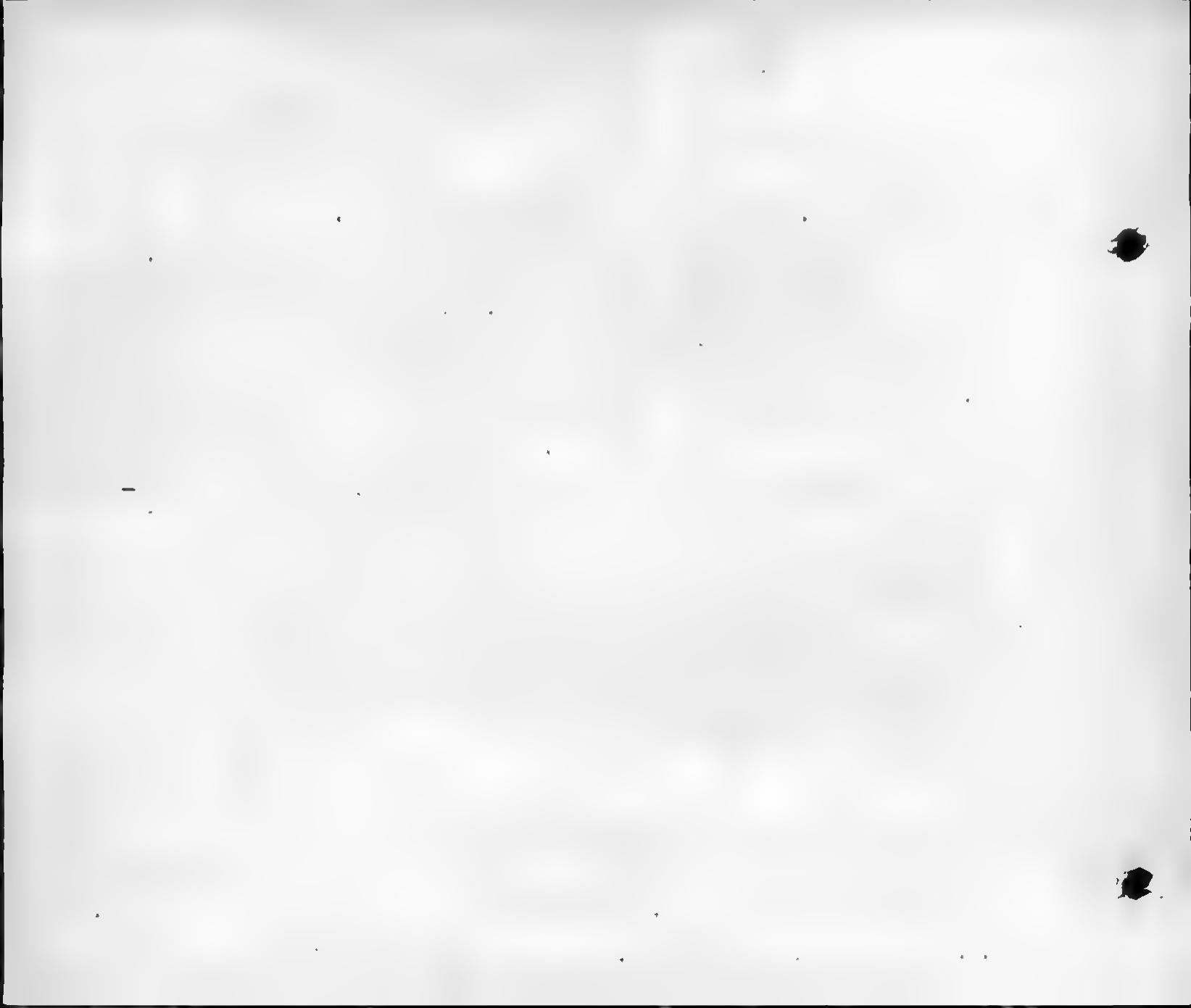
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Montgomery				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington		c. LENGTH OF STAY IN 1b 5 Years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington		d. STREET ADDRESS 10423 Foscett St.		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 10423 Foscett St.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)		First MYRA	Middle NAOMI	Last DELAUTER	4. DATE OF DEATH June 29, 1958	Month June	Day 29	Year 1958
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 23, 1977		9. AGE (In years last birthday) 80 yrs	IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-work		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY USA		
13. FATHER'S NAME J. Newton Whipp				14. MOTHER'S MAIDEN NAME Ann Maria Shellman				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown) No		16. SOCIAL SECURITY NO. Unk		17. INFORMANT M. Josephine DeLauter (Same as item #1)		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) DUE TO				INTERVAL BETWEEN ONSET AND DEATH 5 days Cerebral Hemorrhage Cerebral Arterio Sclerosis Years				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic Heart Disease				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)	(County)	(State)
21. I certify that I attended the deceased from June 10, 1958, to June 29, 1958, that I last saw the deceased alive on June 29, 1958, and that death occurred on June 29, 1958, from the causes and on the date stated above ACTUAL SIGNATURE John J. Lussey M.D. 10620 Geogique Ave. 6/29/58 PHYSICIAN'S NAME (Type)								
22a. BURIAL CREMATION Burial <input type="checkbox"/> (Specify)		22b. DATE THEREOF July 2, 1958		22c. NAME OF CEMETERY OR CREMATORIAL Mt. Olivet Cemetery		22d. LOCATION (City, town, or county) Frederick (State) Md.		
23. FUNERAL DIRECTOR'S SIGNATURE R. Etchison & Son, Frederick, Md.				24a. REC'D BY REGISTRAR DATE JULY 1 '58		24b. REGISTRAR'S SIGNATURE John Smith		

TO HOSPITAL OR CLINIC: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06967

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH

a. COUNTY

MONTGOMERY

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Bethesda

c. LENGTH OF STAY IN 1b

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

Suburban Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)

a. STATE D.C.

b. COUNTY

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

WASH. CITY, D.C. 20592

d. STREET ADDRESS

3200 Oliver St. N.W.

e. IS RESIDENCE ON A FARM?

YES NO 3. NAME OF DECEASED
(Type or print)

First

Middle

Last

4. DATE OF DEATH

Month

Day

Year

5. SEX

Male

6. COLOR OR RACE

White

7. MARRIED NEVER MARRIED WIDOWED DIVORCED

8. DATE OF BIRTH

Sept. 2, 1894

9. AGE (In years
(last birthday))

88 yrs.

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Retired

11. KIND OF BUSINESS OR INDUSTRY

None

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Linus DeLozier

14. MOTHER'S MAIDEN NAME

Cuthwala

15. WAS DECEASED EVER IN U.S. ARMED FORCES?

(Yes, no, or unknown)

No

16. SOCIAL SECURITY NO.

(If yes, give war or date of service)

17. INFORMANT

Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

420.1

DUE TO

Conditions, if any, which
gave rise to immediate
cause (a), stating the under-
lying cause lost.

(b)

DUE TO

(c)

INTERVAL BETWEEN
ONSET AND DEATH

7 days

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED?
YES NO

20a. MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour o. m. 19 p. m.20d. INJURY OCCURRED
While at work Not while at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I attended the deceased from July 23, 1958, to Aug. 23, 1958 that I last saw the deceased alive on July 23, 1958, and that death occurred at 8 AM from the causes and on the date stated above.

ADDRESS (Street, city or town, state)

DATE SIGNED

ACTUAL
SIGNATUREINTERIM
NAME (Type)

Robert B. Kelly MD 5516 Nebraska Ave. DC 6/23/58

22a. BURIAL, CREMATION,
REMOVAL (Specify)

Burial 6/25/58 Date of Burial or Cremation

22b. LOCATION (City, town, or county)

(State)

23. FUNERAL DIRECTOR'S SIGNATURE

Cherry Chase Funeral Home Wash. D.C.

ADDRESS

5703 Wisconsin Ave.

24a. REC'D BY REGISTRAR

DATE JUN 26 '58

24b. REGISTRAR'S SIGNATURE

Deborah



**FOR STATE
HEALTH DEPT.**
TO DEATH MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be used for your files.
TO FUNERAL DIRECTOR: Page 3 should be read as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No 6968

1. PLACE OF DEATH a. COUNTY Montgomery	MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before adm is on) a. STATE Maryland b. COUNTY Montgomery				
b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) Olney	c. LENGTH OF STAY IN lb DOA	e. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) Silver Spring, Rt. #2				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Montgomery County General Hosp	f. STREET ADDRESS Colesville Road	g. IS RESIDENCE ON A FARM YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Frank	First Frank	Middle 	4. DATE OF DEATH DeVilbiss	Month 6-21-58	Day 19	Year
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 7-14-88	9. AGE (In years last birthday) 69 yrs	10. IF UNDER 1 YEAR Months 	11. IF UNDER 24 HRS Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Samuel DeVilbiss		14. MOTHER'S MAIDEN NAME Susan		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service, 		
16. SOCIAL SECURITY NO NONE		17. INFORMANT Lena DeVilbiss		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Corcorny conclusion: 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) (c) DUE TO cause lost. (d)		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> INTERVAL BETWEEN ONSET AND DEATH sudden						
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)				
20c. TIME OF INJURY Hour o. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Riggs, Road, Maryland	(County) 	(State)
21. I certify that I took charge of the remains described above held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>						
ACTUAL SIGNATURE <i>Frank J. Broschart</i>	EXAMINER'S NAME (Type) Frank J. Broschart		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	DATE SIGNED 6-21-58		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 6/23/58	22c. NAME OF CEMETERY OR CREMATORIUM George Washington	22d. LOCATION (City, town, or county) Riggs, Road, Maryland	(State)		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Royce Barber</i>	ADDRESS Laytonsville, Md.	24a. REC'D BY REGISTRAR JUN 24 '58	24b. REGISTRAR'S SIGNATURE <i>Allie Barber</i>			
VS A15ME SM 2-52						



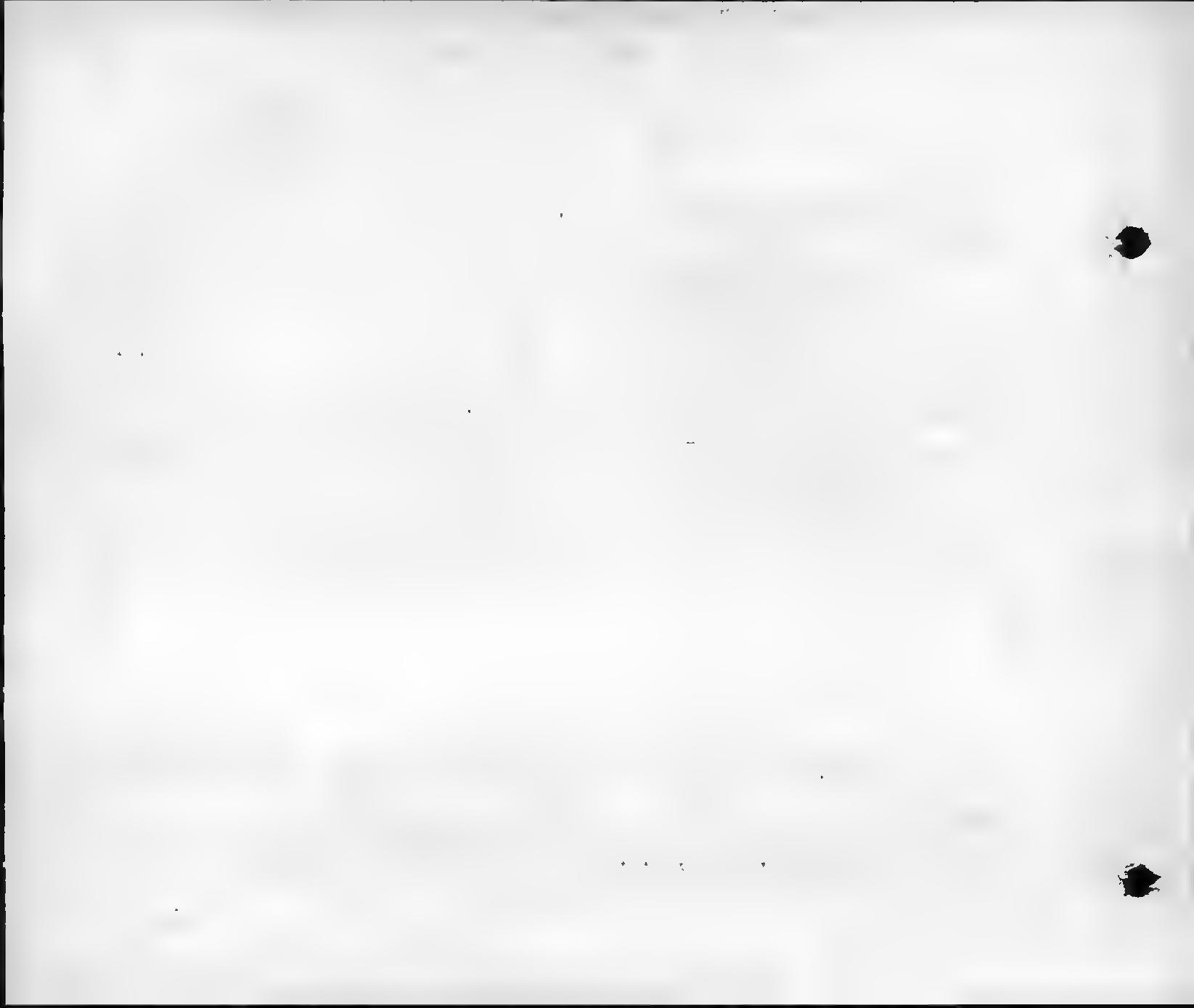
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06969

6997 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o COUNTY Montgomery		MARYLAND	2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before adm is on) o STATE Georgia		b. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN lb 26 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Savannah		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		d. STREET ADDRESS 304 East 67th Street			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3 NAME OF DECEASED (Type or print)	First Shirley	Middle Naomi	Lost	4. DATE OF DEATH June 13, 1958	Month Day Year
5 SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH March 23, 1919	9 AGE (In years lost birthday) 39 yrs.	11 IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	11 BIRTHPLACE (State or foreign country) Georgia		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Harry Marcus		14. MOTHER'S MAIDEN NAME Tillie Mintz			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO 260-01-7421	17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pulmonary embolism</i> DUE TO <i>MECH.</i> Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause, if any (b) <i>post operative cardiac surgery</i> DUE TO (c) <i>congenital aortic stenosis</i> DUE TO INTERVAL BETWEEN ONSET AND DEATH 90 mins					
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED [Enter nature of injury in Part I or Part II of item 18.]			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) The Clinical Center	(County) (State)
21. I certify that I attended the deceased from May 18, 1958, to June 13, 1958, that I last saw the deceased alive on June 13, 1958, and that death occurred at 1:40 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <i>The Clinical Center</i> 6/13/58 The Clinical Center National Institutes of Health Bethesda 14, Maryland					
ACTUAL SIGNATURE <i>James C. Allen</i>		M.D.			
PHYSICIAN'S NAME (Type) James C. Allen, M.D.					
22a. BURIAL CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/16-1958	22c. NAME OF CEMETERY OR CREMATORIAL Bonaventure Cem Savannah Ga	22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Goldsby Funeral Home</i>		ADDRESS 103 W. Walsh St. De	24a. REC'D BY REGISTRAR DATE JUN 16 '58	24b. REGISTRAR'S SIGNATURE <i>W. Edwards</i>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6998

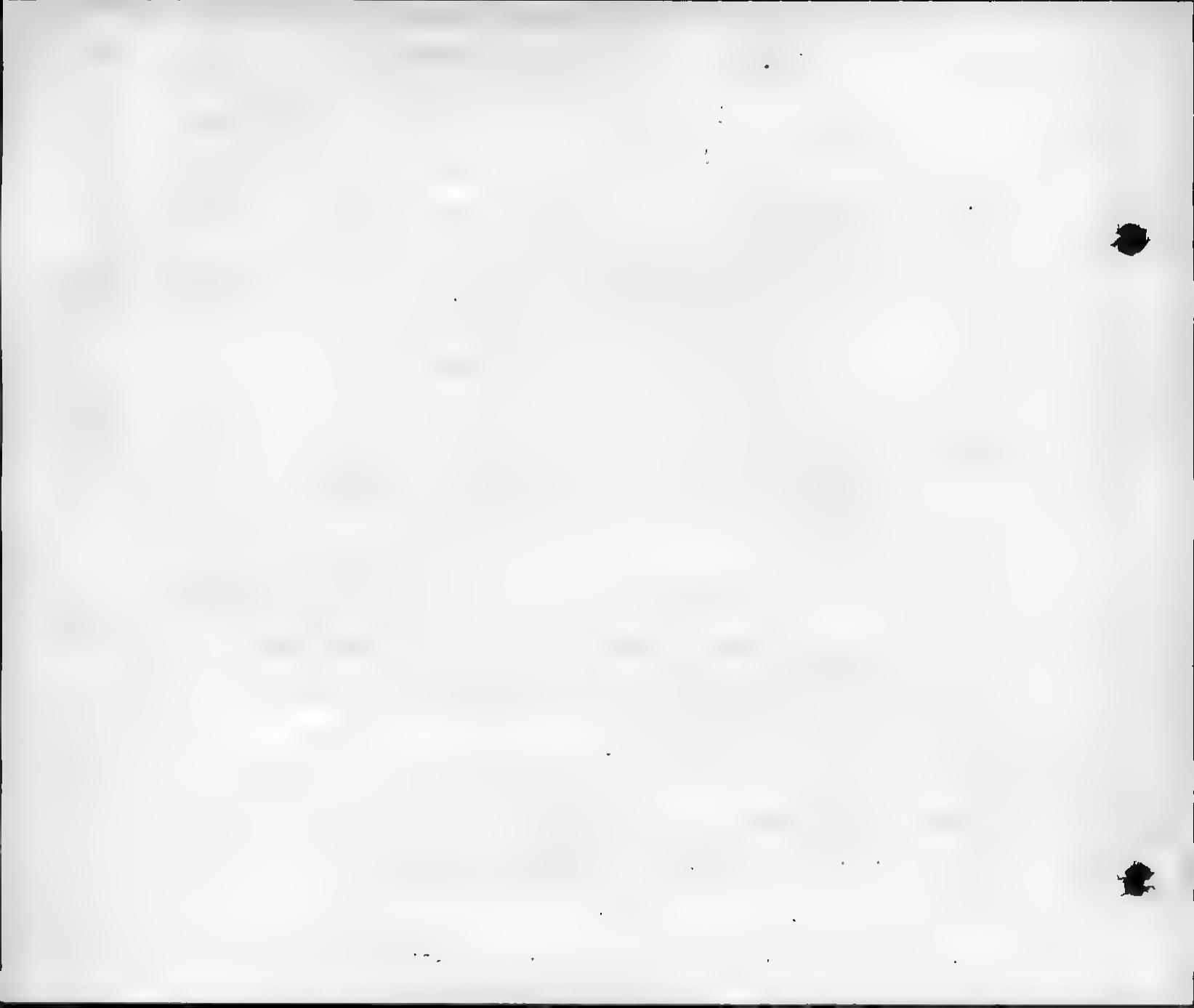
CERTIFICATE OF DEATH

Reg. Dist. No. 215 06970

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 7 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE District of Columbia	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN lb 12 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.				d. STREET ADDRESS 133 "E" Street, N.W.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First John	Middle Joseph	Last EAGLE	4. DATE OF DEATH June 20 1958	Month Day Year
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 20 Feb. 1882	9. AGE (In years last birthday) 76 yrs	10. IF UNDER 1 YEAR Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mariner		10b. KIND OF BUSINESS OR INDUSTRY U.S. Marine Corps (Ret.)		11. BIRTHPLACE (State or foreign country) New York	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown		12. CITIZEN OF WHAT COUNTRY U.S.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) Yes		16. SOCIAL SECURITY NO. WW-I		17. INFORMANT Official Navy Records Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X DUE TO <i>Cerebral Vascular Accident</i> INTERVAL BETWEEN Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) DUE TO (b) DUE TO (c) DUE TO					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8 June 1958, to 20 June 1958, that I last saw the deceased alive on 19 June 1958, and that death occurred at 4:30A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <i>G. E. Gorsuch, Lt, MC, USN</i> U.S. Naval Hospital, Bethesda, Md. 6-20-58					
ACTUAL SIGNATURE <i>G. E. Gorsuch, Lt, MC, USN</i>		PHYSICIAN'S NAME (Type) G. E. GORSUCH, LT, MC, USN U.S. Naval Hospital, Bethesda, Md.			
22a. BURIAL CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-24-58		22c. NAME OF CEMETERY OR CREMATORIUM Arlington Nat'l Cemetery	
22d. LOCATION (City, town, or county) Arlington, Virginia		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <i>R. T. Ryan Inc</i>		ADDRESS R. T. RYAN, 317 PENN. AVE. WASHINGTON, D.C.		24a. REC'D BY REGISTRAR DATE JUN 23 '58	
				24b. REGISTRAR'S SIGNATURE <i>G. E. Gorsuch</i>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6042 CERTIFICATE OF DEATH

06971

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>A.C.</i> b. COUNTY								
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Belvoir Park</i>	c. LENGTH OF STAY IN 1b <i>4 weeks</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Washington</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>517 Library Avenue</i>		d. STREET ADDRESS <i>938 1/2 ST. SW.</i>										
3. NAME OF DECEASED (Type or print) <i>MARY</i>		First <i>MARY</i>	Middle <i>S</i>	Last <i>FARAR</i>	4. DATE OF DEATH <i>June 23, 1958</i>							
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Jan 15, 1873</i>		9. AGE (In years (at birthday) <i>85 yrs</i>	IF UNDER 1 YEAR Months <i>0</i>	IF UNDER 24 HRS Days <i>0</i>	Year <i>1958</i>				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Bkfst Enginner Retired</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Government</i>		11. BIRTHPLACE (State or foreign country) <i>Alexandria, Virginia</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>						
13. FATHER'S NAME <i>George W. Kiley</i>		14. MOTHER'S MAIDEN NAME <i>Emelia Hartley</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. (If yes, give war or date of service) <i>111-11-1111</i>						
17. INFORMANT PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Bronchitis pneumonia</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] DUE TO <i>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <i>24 hours</i>						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Arteriosclerosis, Cardiovascular disease, Debility</i>		20c. TIME OF INJURY Month, Day, Year Hour o. p. n. p. m. <i>June 22, 1958</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>1011 University Blvd E, Silver Spring, Md</i>	20f. (City or town) <i>Silver Spring</i>	(County) <i>Montgomery</i>	(State) <i>Md</i>
21. I certify that I attended the deceased from <i>22 June, 1958</i> to <i>23 June, 1958</i> that I last saw the deceased alive on <i>22 June, 1958</i> , and that death occurred at <i>3:30 PM</i> from the causes and on the date stated above.		ACTUAL SIGNATURE <i>Thomas P. Fogarty, M.D.</i>		ADDRESS (Street, city or town, state) <i>1011 University Blvd E, Silver Spring, Md</i>		DATE SIGNED <i>23 June, 1958</i>						
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>June 26, 1958</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Presbyterian Cemetery</i>		22d. LOCATION (City, town, or county) <i>Alexandria, Virginia</i>		(State) <i>VA</i>				
23. FUNERAL DIRECTOR'S SIGNATURE <i>Paula K. Carter</i>		ADDRESS <i>254 Clarendon St., N.E., D.C.</i>		24a. REC'D BY REGISTRAR <i>REC'D JUN 25 1958</i>		24b. REGISTRAR'S SIGNATURE <i>REC'D JUN 25 1958</i>						

Coroner notified
and will approve
Rogers

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6999

CERTIFICATE OF DEATH

Reg. Dist. No.

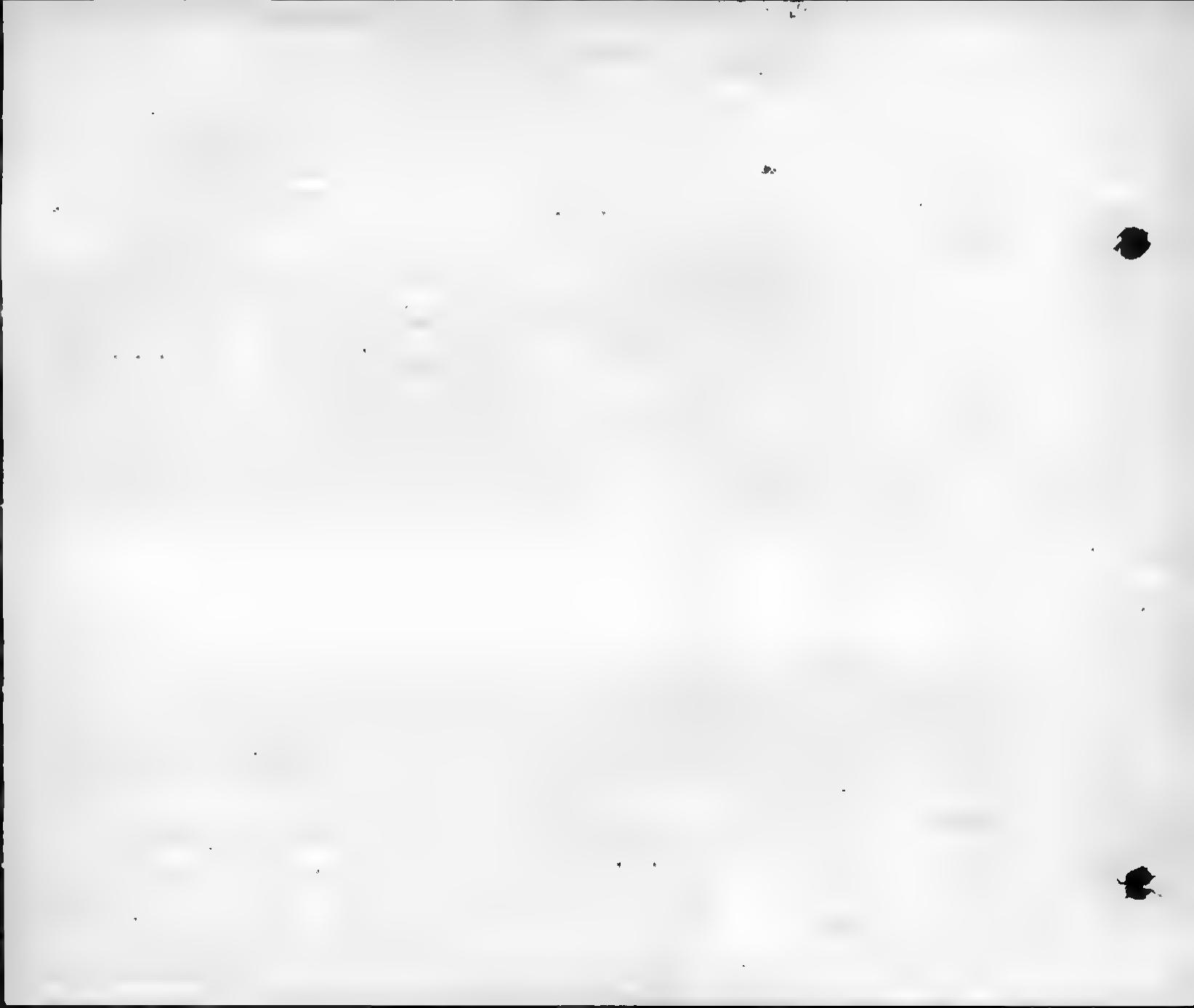
06972

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland		b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN lb 1 day		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		d. STREET ADDRESS 9311 Harrington Drive		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Florence	Middle Duncan	Last Feldman	4. DATE OF DEATH June 16 1958	Month June	Day 16	Year 1958
S. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH November 26, 1924	9. AGE (In years last birthday) 33 yrs	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0	12. IF UNDER 24 HRS Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None -Housewife		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) New York, N.Y.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Pincus Duncan				14. MOTHER'S MAIDEN NAME Miriam Ottenstein			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) No		16. SOCIAL SECURITY NO. 578-20-3155		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 72x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) cardiac arrest				INTERVAL BETWEEN ONSET AND DEATH MINUTES 2 years			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) UREMIA chronic glomerulonephritis				5 years			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 15, 1958 to June 16, 1958 , that I last saw the deceased alive on June 16, 1958 , and that death occurred at 7:45 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Howard Goodman</i>		ADDRESS (Street, city or town, state) The Clinical Center					
PHYSICIAN'S NAME (Type) Howard Goodman, M. D.		DATE SIGNED 6/16/58					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 6-18-58	22c. NAME OF CEMETERY OR CREMATORIUM King David Memorial Garden		22d. LOCATION (City, town, or county) Falls Church		(State) Va.	
23. FUNERAL DIRECTOR'S SIGNATURE B. Danzansky & Sons 3501 14th St., N.W., Wash.10				24a. REC'D BY REGISTRAR JUN 19 '58		24b. REGISTRAR'S SIGNATURE <i>Abel Green</i>	

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

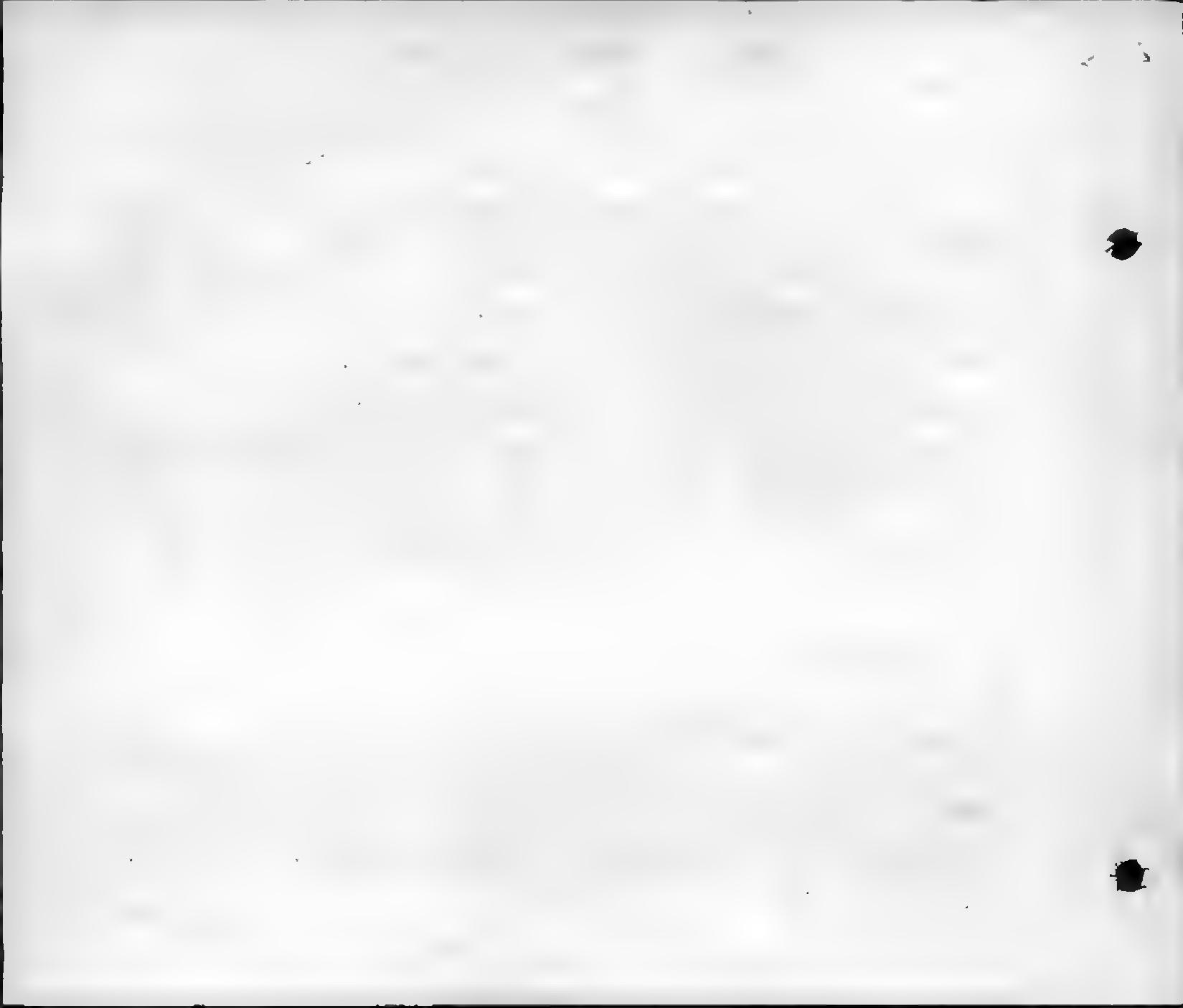


MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
700 CERTIFICATE OF DEATH

Reg. Dist. No.

06973

1. PLACE OF DEATH a. COUNTY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE	
Montgomery				Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb		b. COUNTY	
Bethesda				Montgomery	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
SUBURBAN		14816 Montgomery Lane			
3. NAME OF DECEASED (Type or print)	First	Middle	Last	4. DATE OF DEATH	Month Day Year
Fannie		H	Field	June 17	1958 19
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday) yrs.	10. IF UNDER 1 YEAR OR UNDER 24 HRS Months Days Hours Min
Female	W		8/1/82	70	10 16 00 00
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
H.W.		Own Home		New York	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
Charles Echette		Sophie Olson		U.S.A.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO		17. INFORMANT	
(If yes, give war or dates of service)		Unknown		Frances H. O'Shaughnessy	
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a)		DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first		(b)		Intracerebral edema	
{		DUE TO		4 days	
(c)		Toxemia			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		artiononephrosclerosis			
20c. TIME OF INJURY Month Day Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
19				1835 Eye St. N.W. Washington, D.C.	
21. I certify that I attended the deceased from 6-14, 1958, to 6-17, 1958, that I last saw the deceased alive on 6-17, 1958, and that death occurred at 1:50 P.M., from the causes and on the date stated above.					
ADDRESS (Street, city or town, state)					
ACTUAL SIGNATURE Walter Atkinson M.D.					
PHYSICIAN'S NAME (Type) WALTER ATKINSON 1835 Eye St. N.W. Washington, D.C.					
22a. BURIAL CREMATION, REMOVAL (Specify) Burial transit 6/26/58		22b. DATE THEREOF 6/26/58		22c. NAME OF CEMETERY OR CREMATORIAL Kenisco Cemetery	
22d. LOCATION (City, town, or county)				(State)	
22d. LOCATION (City, town, or county) Montgomery County, Maryland				(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Robert C. Clegg		ADDRESS Bethesda, Maryland		24a. REC'D BY REGISTRAR DUN 23 '58	
				24b. REGISTRAR'S SIGNATURE All ready	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7001

CERTIFICATE OF DEATH

Reg. Dist. No.

06974

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
to be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 12 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburb-n Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington Grove	
3. NAME OF DECEASED (Type or print) Army		d. STREET ADDRESS 4 th venue	
4. DATE OF DEATH Fields		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 5/14/93
9. AGE (In years from last birthday) 65 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0	11. IF UNDER 24 HRS Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired.		10b. KIND OF BUSINESS OR INDUSTRY Farmer	
11. BIRTHPLACE (State or foreign country) Martinsburg, Maryland		12. CITIZEN OF WHAT COUNTRY? Erica	
13. FATHER'S NAME Clayton S. Fields		14. MOTHER'S MAIDEN NAME Francis Wood	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. —	
17. INFORMANT Mrs. Harriet Long		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary embolism 434.4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first } (b) DUE TO { (c) Congestive heart failure Cor pulmonale	
		INTERVAL BETWEEN ONSET AND DEATH 2 days	
		1 week	
		4 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. —		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Beallsville (County) Md (State) Md	
21. I certify that I attended the deceased from 6-1-1958 to 6-12-1958 , that I last saw the deceased alive on 6-11-1958 , and that death occurred at — M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 931 Kerbside Drive Silver Spring, Md. DATE SIGNED 6-17-58			
ACTUAL SIGNATURE Jason Geiger		PHYSICIAN'S NAME (Type) JASON GEIGER	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/14/58	
22c. NAME OF CEMETERY OR CREMATORIAL Monocacy		22d. LOCATION (City, town, or county) Beallsville Md (State) Md	
23. FUNERAL DIRECTOR'S SIGNATURE William B. Hilton, Bernardsville, N.J.		ADDRESS	
24a. REC'D BY REGISTRAR DATE JUN 16 '58		24b. REGISTRAR'S SIGNATURE Deborah	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06975

7002

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Virginia		b. COUNTY Arlington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 19 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arlington			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		d. STREET ADDRESS 3642 North Piedmont Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Floyd	Middle Grayston	Last Fisher	4. DATE OF DEATH	Month June	Day 7	Year 1958
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH March 15, 1910	9. AGE (In years lost birthday) 48 yrs	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. Hours Min
10a. US/L OCCUPATION (Give kind of work done during most of working life, even if retired) Mathematician		10b. KIND OF BUSINESS OR INDUSTRY Government		11. BIRTHPLACE (State or foreign country) Indiana		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Marvin Fisher			14. MOTHER'S MAIDEN NAME Ida Schlagel				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO None		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Hepatotoxic acetaminum all sarcana</i> DUE TO 200.0 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Chronic passive & thrombocytopenic purpura</i>							
INTERVAL BETWEEN ONSET AND DEATH 1 yr.							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <i>May 18, 1958</i>					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 18, 1958 to June 7, 1958, that I last saw the deceased alive on June 7, 1958, and that death occurred at 4:45 AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center The National Institutes of Health Bethesda 14, Maryland							
DATE SIGNED 6-7-58							
ACTUAL SIGNATURE <i>Lawrence Schlachter</i> M.D.							
PHYSICIAN'S NAME (Type) Lawrence Schlachter, M. D.							
22a. BURIAL CREMATION, REMOVAL (Specify) Cremation	22b. DATE THEREOF June 9, 1958	22c. NAME OF CEMETERY OR CREMATORIAL Cedar Hill	22d. LOCATION (City, town, or county) Suitland, Maryland	(State)			
23. FUNERAL DIRECTOR'S SIGNATURE C. P. Deemers	ADDRESS 2847 Wilson Blvd Arlington, Va	24a. REC'D BY REGISTRAR JUN 10 1958	24b. REGISTRAR'S SIGNATURE A. Deemers				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-tranit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

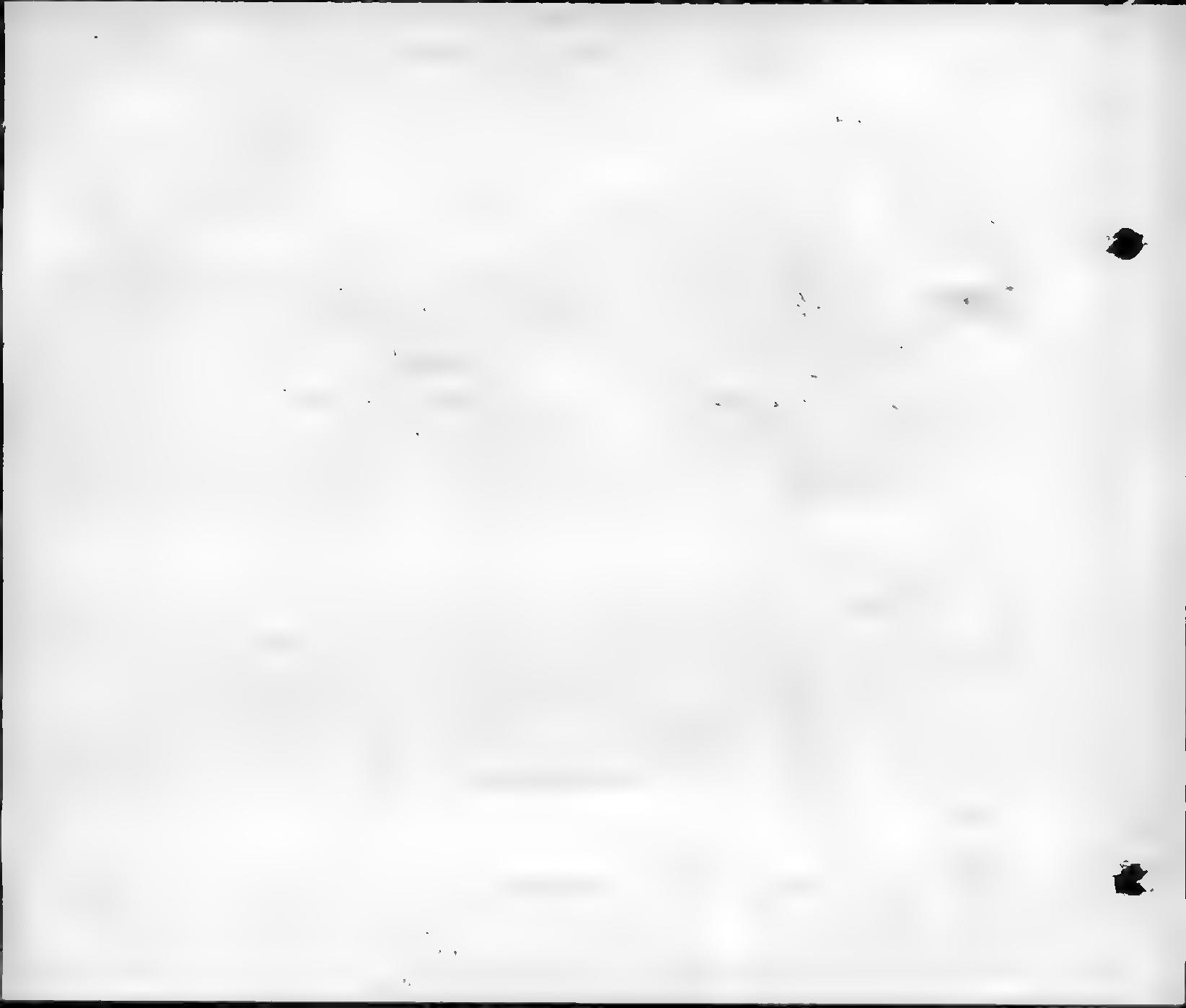
7003

CERTIFICATE OF DEATH

Reg. Dist. No.

06976

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) b. STATE	
Montgomery Maryland		DC	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
Hensington		Washington	
d. NAME OF HOSPITAL (If not in hospital, give street address) or INSTITUTION	d. STREET ADDRESS		
HENSINGTON GARDENS	6433-8-st. nw		
3. NAME OF DECEASED (Type or print)	First	Middle	Last
Julian	S	Freeman	6
4. DATE OF DEATH	Month	Day	Year
	6	12	1958
5. SEX	6. COLOR OR FACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH
Male	white		Nov. 9, 1868 89
9. AGE (In years lost last birthday) yrs.	10. IF UNDER 1 YEAR: IF UNDER 24 MRS. Months Days Hours Min		
10a. LIFELONG OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Saleman	Bakery	Md.	
13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME		
James W Freeman		Mary Dent	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address
Yes, no, or unknown		Soldier by FIREMAN	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			
DUE TO			
Acute congestive heart failure			
INTERVAL BETWEEN ONSET AND DEATH (2 hrs.)			
Conditions, if any, which gave rise to immediate cause (a), listing the under- lying cause first. (b)			
DUE TO			
arterio sclerotic heart disease			
10 yrs			
(c) generalized arterio sclerosis			
20 yrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
19			
21. I certify that I attended the deceased from <u>Dec.</u> , 19 <u>45</u> , to <u>June 12, 1958</u> that I last saw the deceased alive on <u>June 12, 1958</u> , and that death occurred at <u>8:25 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE	ADDRESS (Street, city or town, state)		
<u>A. Kreuzburg</u>	M.D. 7852 16 New York 12 6/12/58		
PHYSICIAN'S NAME (Type)	DATE SIGNED		
<u>A. F. Kreuzburg</u>	6/12/58		
22a. BURIAL, CREMATION, OR REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORIUM	22d. LOCATION (City, town, or county) (State)
Burial	6-14-58	Woodlawn	Washington D.C.
23. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS	24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE
<u>J. W. Kreuzburg Son</u>	<u>Woodlawn D.C.</u>	<u>JUN 16 1958</u>	<u>Rec'd 6/16/58</u>



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7004

CERTIFICATE OF DEATH

Reg. Dist. No.

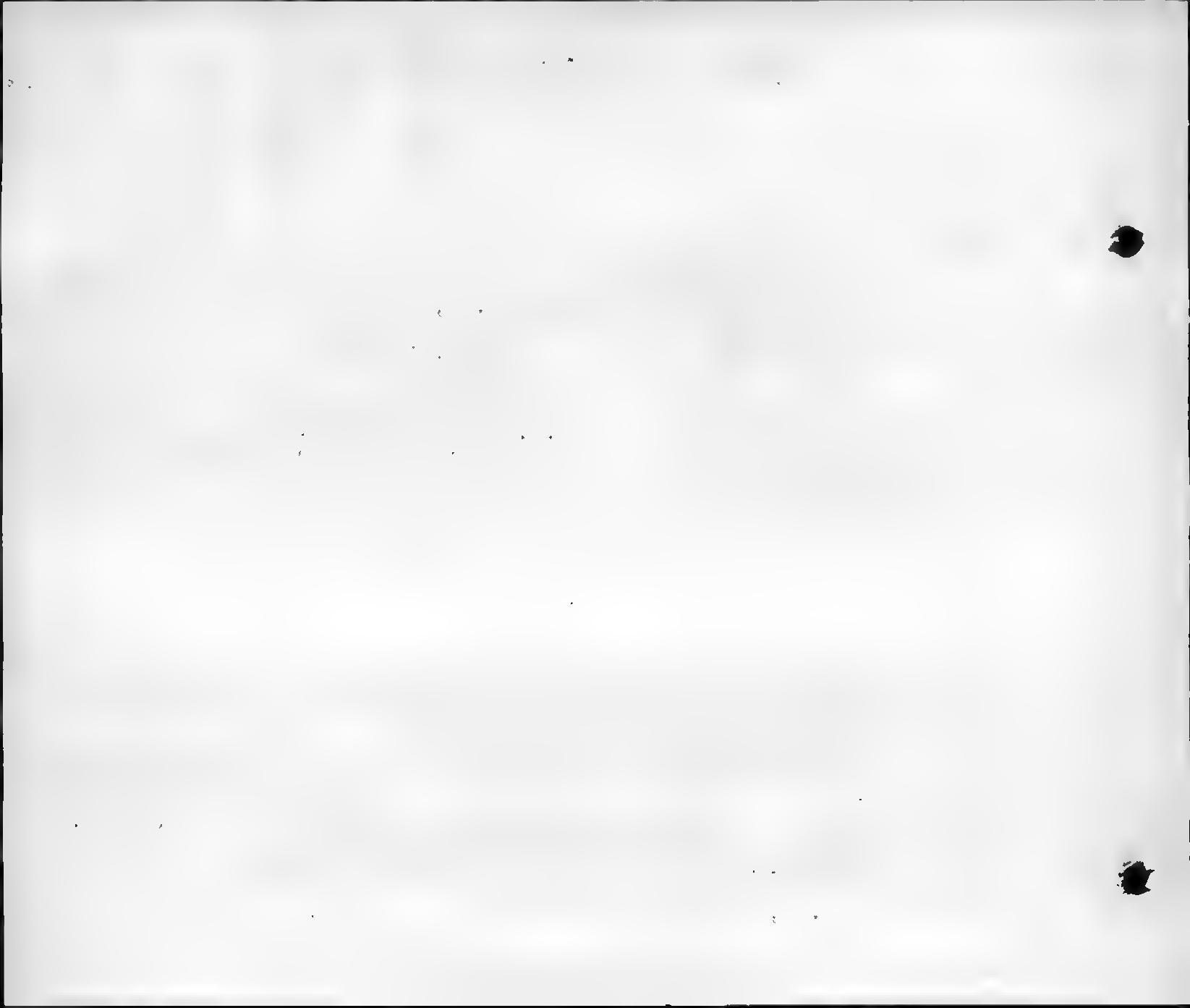
06977

1. PLACE OF DEATH a. COUNTY MONTGOMERY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND		b. COUNTY ANNE ARUNDEL		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANAPOLIS		d. STREET ADDRESS		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MARILEA NURSING HOME						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF (Type or print) AMY ELIZABETH GAMBRILL		First	Middle	Last	4. DATE OF DEATH JUNE 15	Month	Day	Year 19 58
5. SEX FEMALE		6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH Sept. 19, 1892	9. AGE (In years less birthday) 65	IF UNDER 1 YEAR Months 8	IF UNDER 24 HRS Days 26	Hours Min.
8. OCCUPATION (Give kind of work done during most of working life, even if retired) House Work at Home		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Allen, Maryland		12. CITIZEN OF WHAT COUNTRY U S A		
13. FATHER'S NAME John Murray		14. MOTHER'S MAIDEN NAME Mava Bounds						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT R. L. Howard Gambrill (Husband) Address: Academy Seafood, Annapolis, Maryland				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 332X DUE TO <i>Cerebral Thrombosis & infarction</i>						INTERVAL BETWEEN ONSET AND DEATH		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) DUE TO <i>Varicose</i>								
(c) DUE TO <i>Cerebral arteriosclerosis.</i>								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Carcinoma.						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Injury occurred at home.						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> Not while at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 809 Viers Mill Road		20f. (City or town) Allen	(County) Maryland	(State) MD
21. I certify that I attended the deceased from June 15, 1958 to June 15, 1958 , that I last saw the deceased alive on June 15, 1958 , and that death occurred at 10 AM , from the causes and on the date stated above ADDRESS (Street, city or town, state) 809 Viers Mill Road								
ACTUAL SIGNATURE Stephen N. Jones						DATE SIGNED JUNE 15, 1958		
PHYSICIAN'S NAME (Type) STEPHEN N. JONES				SILVER SPRING, MARYLAND				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jun. 18, 1958		22c. NAME OF CEMETERY OR CREMATORIUM Allen Cemetery		22d. LOCATION (City, town, or county) Allen, Maryland		
23. FUNERAL DIRECTOR'S SIGNATURE HOLZWAY & COMPANY		ADDRESS SALISBURY MARYLAND		24a. REC'D BY REGISTRAR DATE JUN 18 '58		24b. REGISTRAR'S SIGNATURE Albert Smith		

TO HOSPITAL ■ ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
7005 CERTIFICATE OF DEATH

06978

Reg. Dist. No. 215

1.		TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.												
2.		TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit Permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.												
M I 2		1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE District of Columbia									
		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)			c. LENGTH OF STAY IN 1b 35 days									
		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Maryland			e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington			f. STREET ADDRESS 3305 Macomb Street, N.W.			g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
		3. NAME OF DECEASED (Type or print) Robert Lee GHORMLEY			4. DATE OF DEATH June 21 1958			Month Day Year						
		5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 15 October 1883			9. AGE (In years lost birthday) 74 yrs	10. IF UNDER 1 YEAR Months Days Hours Min		11. IF UNDER 24 HRS			
		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mariner			10b. KIND OF BUSINESS OR INDUSTRY U.S. Navy Retired			11. BIRTHPLACE (State or foreign country) Oregon			12. CITIZEN OF WHAT COUNTRY? U.S.			
		13. FATHER'S NAME David O. GHORMLEY			14. MOTHER'S MAIDEN NAME Alice M. ERWIN									
		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes or no; or unknown) Yes WW-I, WW-II			16. SOCIAL SECURITY NO WW-1, WW-II			17. INFORMANT (Son) Robert L. GHORMLEY Jr.	Address 5408 Christy Dr. Washington, D.C.					
MEDICAL CERTIFICATION		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 101.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) DUE TO (c) <i>Aspirations / Aspiration Pneumonia</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)						INTERVAL BETWEEN ONSET AND DEATH 3 months						
		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						
		20c. TIME OF INJURY Hour o. m. p. m.	Month 19	Year	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)					
		21. I certify that I attended the deceased from 17 May 1958, to 21 June 1958, that I last saw the deceased alive on 21 June 1958, and that death occurred at 7:40P.M. from the causes and on the date stated above									ADDRESS (Street, city or town, state)	DATE SIGNED		
		ACTUAL SIGNATURE <i>Melvin Rotner</i>			M.D. U.S. Naval Hospital, Bethesda, Md. 6-22-58									
		PHYSICIAN'S NAME (Type) MELVIN ROTNER, LT, MC, USN			U.S. Naval Hospital, Bethesda, Md.									
		22a. BURIAL, CREMATION REMOVAL (Specify) Burial	22b. DATE THEREOF 6-25-58	22c. NAME OF CEMETERY OR CREMATORIAL Arlington Nat'l Cemetery			22d. LOCATION (City, town, or county) Arlington, Virginia			(State)				
		23. FUNERAL DIRECTOR'S SIGNATURE Joseph Gowler's & Sons			ADDRESS Washington, D.C.			24a. REC'D BY REGISTRAR JUN 24 '58	24b. REGISTRAR'S SIGNATURE <i>Dee E. Miller</i>					



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06979

6944

CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <i>Montgomery</i>		MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Prince Georges</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		c. LENGTH OF STAY IN lb <i>5 hours 39 min</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>West Hyattsville</i>		d. STREET ADDRESS <i>2000 Oglethorpe Street</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR, INSTITUTION <i>Washington Sanitarium + Hospital</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Infant</i>		First <i>Girl</i>	Middle <i>Gladstone</i>	4. DATE OF DEATH <i>June 21</i>	Month <i>June</i>	Day <i>21</i>	Year <i>1958</i>
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>June 21, 1958</i>	9. AGE (In years from last birthday) yrs. <i>0</i>	IF UNDER 1 YEAR Months <i>5</i>	IF UNDER 24 HRS Days <i>0</i>	IF UNDER 24 HRS Hours <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>None</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>None</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Edward Amos Gladstone</i>		14. MOTHER'S MAIDEN NAME <i>Ruth Laura Simmons</i>		Address			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>		17. INFORMANT <i>Mother's chart</i>		INTERVAL BETWEEN ONSET AND DEATH <i>None</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Birth</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Hour a. m. p. m.	Month <i>June</i>	Day <i>21</i>	Year <i>1958</i>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>None</i>	20f. (City or town) <i>None</i>	(County) (State)
21. I certify that I attended the deceased from <i>June 21, 1958</i> to <i>June 21, 1958</i> , that I last saw the deceased alive on <i>June 21, 1958</i> , and that death occurred at <i>4:27 p.m.</i> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>9210 Colesville Rd, Silver Spring, Md.</i> DATE SIGNED <i>Sydney Leventhal, M.D.</i>							
ACTUAL SIGNATURE <i>Sydney Leventhal, M.D.</i>							
PHYSICIAN'S NAME (Type) <i>Sydney Leventhal, M.D.</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Cremation</i>	22b. DATE THEREOF <i>6-22-58</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Wash. San. and Hosp.</i>	22d. LOCATION (City, town, or county) <i>Takoma Park, Wash. 12, D.C.</i> (State)				
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert A. Hare, M.D.</i>		ADDRESS <i>Takoma Park 12, Washington San. & Hosp.</i>	24a. REC'D BY REGISTRAR <i>D.C.</i>	24b. REGISTRAR'S SIGNATURE <i>Ques</i>			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7006

CERTIFICATE OF DEATH

Reg. Dist. No.

06980

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be used with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH o COUNTY <i>Montgomery Co. MARYLAND</i>		2. USUAL RESIDENCE (Where deceased lived. If institutional Residence before admission) o STATE <i>Md.</i> b. COUNTY <i>Mont. Co.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>	c. LENGTH OF STAY IN 1b <i>21 days</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rockville</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>St. Lukes Hosp.</i>		d. STREET ADDRESS <i>427 McArthur St.</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <i>James</i>	Middle <i>Leaven</i>	Last <i>Godsey</i>
4. DATE OF DEATH	Month <i>June</i>	Day <i>21</i>	Year <i>1958</i>
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>July 2 1883</i>
9. AGE (In years last birthday) <i>74 yrs.</i>		10. IF UNDER 1 YEAR Months <i>11</i> Days <i>19</i>	11. IF UNDER 24 HRS Hours <i>11</i> Min. <i>00</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Teacher - Retired</i>		11. BIRTHPLACE (State or foreign country) <i>Tennessee</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
13. FATHER'S NAME <i>William W. Godsey</i>		14. MOTHER'S MAIDEN NAME <i>? Wood</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>Unknown</i>	
17. INFORMANT <i>Mr. India Godsey (Name is a alias)</i>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Cerebral thrombosis c. Right</i>		INTERVAL BETWEEN ONSET AND DEATH <i>14 days</i>	
DUE TO <i>Hemiplegia followed by left Hemiplegia</i>		6 days	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Cerebral arteriosclerosis</i>			
DUE TO (c) <i>Cerebral arteriosclerosis</i>			
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <i>Rockville</i> (County) <i>Montgomery Co.</i> (State) <i>Md.</i>	
21. I certify that I attended the deceased from <i>6/9/58</i> , 19, to <i>6/21/58</i> , 19, that I last saw the deceased alive on <i>6/20/58</i> , 19, and that death occurred at <i>6:30 P.M.</i> from the causes and on the date stated above			
ACTUAL SIGNATURE <i>William Frank</i>		ADDRESS (Street, city or town, state) <i>544 W. MONTGOMERY AVE Rockville, Md.</i> DATE SIGNED <i>6/21/58</i>	
PHYSICIAN'S NAME (Type) <i>WILLIAM FRANK, M.D.</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Bur. transit</i>		22b. DATE THEREOF <i>6/22/1958</i>	
22c. NAME OF CEMETERY OR CREMATORIUM <i>Sivley Cem.</i>		22d. LOCATION (City, town, or county) <i>Chattanooga, Tennessee</i> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert A. Pumphrey-7557 Wis. Ave. Bethesda, Md.</i>		24. REC'D BY REGISTRAR <i>JUN 25 '58</i>	
ADDRESS <i>MR</i>		REG STAR'S SIGNATURE <i>Albrecht</i>	

1 2 3 4

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06981

7007

CERTIFICATE OF DEATH

Reg. Dist. No. 215 m

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 5 mos. 2 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Maryland		d. STREET ADDRESS 4510 Highland Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Lucy	Middle Russell	Last GOLDSBY	4 DATE OF DEATH June	Month June	Day 13	Year 19 58
5. SEX Female	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 17 March 1889	9. AGE (in years (last birthday) 69 yrs	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS Hours 0	Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nursing		10b. KIND OF BUSINESS OR INDUSTRY U.S. Navy, Retired		11. BIRTHPLACE (State or foreign country) Maryland		12 CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME John Russell				14. MOTHER'S MAIDEN NAME Lucy Herbert			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes 5-4-17 to 1-7-34		16. SOCIAL SECURITY NO Unknown		17. INFORMANT Son, John R. Goldsby, 4519 Highland Ave.,		Address Bethesda, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 480.0 DUE TO Chronic Pneumonia INTERVAL BETWEEN Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) Chronic Congestive Heart Failure 6 mos. DUE TO (c) Atherosclerotic Heart Disease unknown							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 4491X							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> TO CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2 January 19 58 to 13 June 19 58, that I last saw the deceased alive on 13 June 19 58, and that death occurred at 8:40A.M. from the causes and on the date stated above ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md. 6-13-58 DATE SIGNED ACTUAL SIGNATURE <i>B. Dunn Jr.</i> PHYSICIAN'S NAME (Type) T.S. DUNN, JR. LT, MC, USN U.S. Naval Hospital, Bethesda, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-18-58		22c. NAME OF CEMETERY OR CREMATORIUM Arlington Natl Cemetery		22d. LOCATION (City, town, or county) Arlington, Virginia (State)	
24c. FUNERAL DIRECTOR'S SIGNATURE <i>R.C. McAnally</i>		ADDRESS R.A. Pumphrey, 7587 Wisconsin Ave., Bethesda, Md.		24a. REG'D BY REGISTRAR SUN 16 58 DATE		24b. REGISTRAR'S SIGNATURE <i>John E. Quinn</i>	



MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

7008

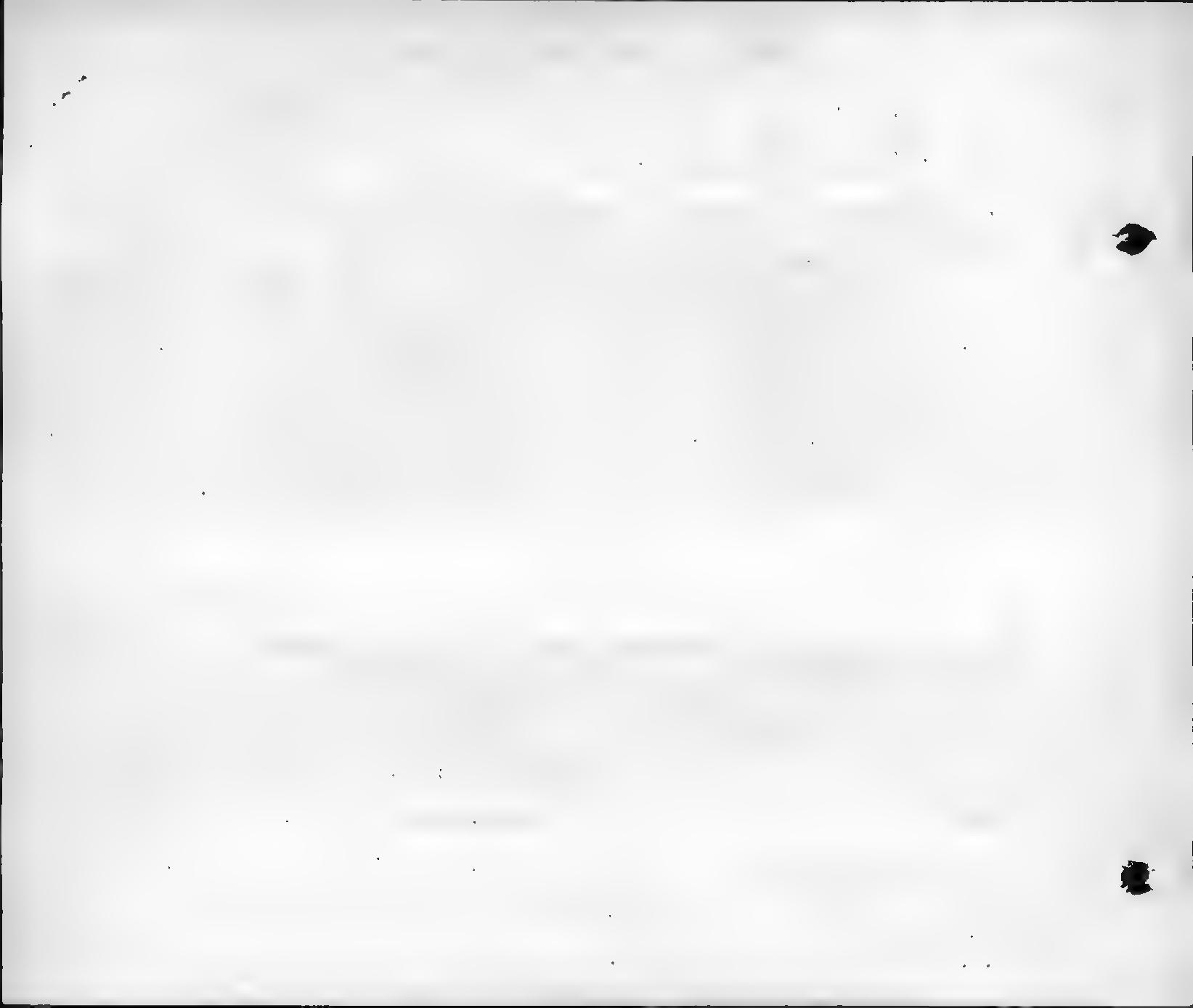
CERTIFICATE OF DEATH

Reg. Dist. No.

06982
215

1 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.
 1 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 Page 3 should be detached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE District of Columbia		COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN lb 14 hr. 26 min.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington			
d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Maryland		d. STREET ADDRESS 1213½ "C" Street, N.E.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Baby	Middle Boy	Last GOODING	4. DATE OF DEATH	Month June	Day 4	Year 19 58
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3 June 1958		9. AGE (In years lost birthday) yrs. 14 1/2	10. IF UNDER 1 YEAR IF UNDER 24 HRS Months 14 Days 1/2 Month May Day 26	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY --		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Clarence Wilson GOODING				14. MOTHER'S MAIDEN NAME Virginia Lee RICHARDSON			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Official Navy Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) RESPIRATORY FAILURE (ATELECTASIS) INTERVAL BETWEEN ONSET AND DEATH 16 1/2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) PREMATURITY DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o m p. m.	Month June	Day 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> At work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Arlington	(County) Arlington	(State) Virginia
21. I certify that I attended the deceased from 3 June 1958 , to 4 June 1958 , that I last saw the deceased alive on 4 June 1958 , and that death occurred at 1:00 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md. DATE SIGNED 6-6-58							
ACTUAL SIGNATURE <i>Daniel Shuptar</i>	M.D. U.S. Naval Hospital, Bethesda, Md.						
PHYSICIAN'S NAME (Type) DANIEL SHUPTAR, LT MC USN	U.S. Naval Hospital, Bethesda, Md.						
22a. BURIAL, CREMATION REMOVAL (Specify) BURIAL*	22b. DATE THEREOF 6-11-58	22c. NAME OF CEMETERY OR CREMATORIUM Arlington Natl Cemetery		22d. LOCATION (City, town or county) Arlington, Virginia		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>R.A. Pumphrey</i>	ADDRESS 7557 Wisconsin Ave., Bethesda, Md.	24a. REC'D BY REGISTRAR JUN 10 '58		24b. REGISTRAR'S SIGNATURE <i>Alfred J. Smith</i>			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06983

6945

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <i>Washington, D.C.</i>		b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park, Md.</i>		c. LENGTH OF STAY IN 1b RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Washington Sanitarium & Hospital</i>		d. STREET ADDRESS <i>2029 P St., N.W.</i>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Washington Sanitarium & Hospital</i>				d. STREET ADDRESS <i>41X</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <i>Frances Eleanor Buchanan</i>		First	Middle	Last	4. DATE OF DEATH <i>June 3 1958</i>	Month	Day	Year
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>4-1-81</i>	9. AGE (In years last birthday) <i>77 yrs</i>	IF UNDER 1 YEAR, IF UNDER 24 HRS Months Days Hours Min		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired Steno</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Virginia</i>		12. CITIZEN OF WHAT COUNTRY? <i>American</i>		
13. FATHER'S NAME <i>Wilbur Buchanan</i>		14. MOTHER'S MAIDEN NAME <i>Lucy Payne</i>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Pt's chart</i>		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.0</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		<i>Alzheimer</i>				INTERVAL BETWEEN ONSET AND DEATH <i>7 days</i>		
		<i>Neurofibrillary vascular papillitis</i>				<i>7 days</i>		
		<i>Backward endocarditis</i>						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Obstruction of common bile duct by calculi</i>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from <i>6/1/58</i> to <i>6/3 1958</i> that I last saw the deceased alive on <i>6/3 1958</i> , and that death occurred at <i>6:45 p.m.</i> from the causes and on the date stated above. ACTUAL SIGNATURE <i>Raymond O. West</i>						ADDRESS (Street, city or town, state) <i>M.D. 7600 Carroll Ave. Takoma Park, Md.</i>		
22a. BURIAL CREMATION, REMOVAL (Specify) <i>Removal</i>		22b. DATE THEREOF <i>6/6/58</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>Buchanan Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Buchanan, Virginia</i>		
23. FUNERAL DIRECTOR'S SIGNATURE <i>The S. H. Hines Co. - 2901 14th St., N.W.</i>		ADDRESS <i>Wash. D.C.</i>		24a. REC'D BY REGISTRAR DATE <i>JUN 6 '58</i>		24b. REGISTRAR'S SIGNATURE <i>W. esch</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 24 hours after death. Page 1 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 10/57

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X MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06984

7009

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY

Montgomery

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Silver Spring

c. LENGTH OF STAY IN lb

10 days

d. NAME OF HOSPITAL (If not in hospital, give street address)
OR INSTITUTION

9301 Weaver Street

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE Maryland

b. COUNTY

Montgomery

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Silver Spring

d. STREET ADDRESS

110 E. Schuyler Road

e. IS RESIDENCE
ON A FARM?
YES NO 3. NAME OF
DECEASED
(Type or print)

First REINE Middle AGNES Last G-RAND

5. SEX

FEMALE

6. COLOR OR RACE

White

7. MARRIED NEVER MARRIED WIDOWED DIVORCED

8. DATE OF BIRTH

9. AGE (In years
lost birthday)

73 yrs.

10. USUAL OCCUPATION (Give kind of work done
during most of working life, even if retired)

Housewife

11. BIRTHPLACE (State or foreign country)

Washington, D. C.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

John Rochon

14. MOTHER'S MAIDEN NAME

Marie Wagner

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL SECURITY NO.

none

17. INFORMANT

Mr. Joseph A. Grand, 310 Brewster Court

Address

Silver Spring, MD

INTERVAL BETWEEN
ONSET AND DEATH

ONE MONTH

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

DUE TO

Conditions, if any, which

gave rise to immediate

cause (a), stating the under-

lying cause last.

(b)

DUE TO

(c)



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be recorded within 24 hours after death. If any delay is necessary, please enter the certificate, writing the word "Pending". In pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PHM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-trust permit. File pages 1 and 2 with the State Board of Health, or in designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06985

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>MARYLAND</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		c. LENGTH OF STAY IN lb <i>D.O.A.</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>St. Luke's</i>		X Bethesda 1/24/58	
e. STREET ADDRESS <i>1041 1/2 St. in Bethesda</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Carrie</i>		First <i>Carrie</i>	Middle <i>LUCILLE</i>
4. DATE OF DEATH Year <i>JUN 19 1958</i>		5. SEX Female	6. COLOR OR RACE White
7. MARRIED WIDOWED <input checked="" type="checkbox"/>		8. NEVER MARRIED DIVORCED <input type="checkbox"/>	9. DATE OF BIRTH <i>5-14-1884</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>HOMEMAKER</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>HOME</i>	
11. BIRTHPLACE (State or foreign country) <i>MONT. CO. MARYLAND</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>HENLEY</i>		14. MOTHER'S MAIDEN NAME <i>MARGARET MULLICAN</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO <i>NONE</i>	
17. INFORMANT <i>Mr. NORMAN A. GRAY</i>		Address <i>ARLINGTON 5, VA. 6249 N. WASH. BLVD.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary occlusion</i>			
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>Hypertension</i>			
DUE TO (b)			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Frank J. Broschart</i>		DATE SIGNED <i>6/19/58</i>	
EXAMINER'S NAME (Type) <i>Frank J. Broschart</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>6/21/58</i>	
22c. NAME OF CEMETERY OR CREMATORIUM <i>Cedar Hill Cemetery</i>		22d. LOCATION (City, town, or county) <i>Suitland, Maryland</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert A. Murphy, Bethesda, Maryland</i>		24a. REC'D BY REGISTRAR DATE <i>JUN 23 '58</i>	
		24b. REGISTRAR'S SIGNATURE <i>John Deane</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-trust permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and many event within 72 hours after death.

VIS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 7011

CERTIFICATE OF DEATH

Reg. Dist. No. 06986

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Burtonsville</i>		c. LENGTH OF STAY IN 1b <i>2 weeks</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>None</i>		e. STREET ADDRESS <i>Rowe Hill Rd.</i>	
f. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <i>Charles</i>	Middle <i>Franklin</i>	Last <i>Gregg</i>
4. DATE OF DEATH Month <i>6</i>	Day <i>7</i>	Year <i>1958</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>9/22/1896</i>
9. AGE (In years at death) <i>62 yrs.</i>	10. USUAL OCCUPATION (Give kind of work done during most of working-life, even if retired) <i>Farmer</i>	11. KIND OF BUSINESS OR INDUSTRY <i>Farm</i>	12. BIRTHPLACE (State or foreign country) <i>Maryland</i>
13. FATHER'S NAME <i>William Elias Gregg</i>	14. MOTHER'S MAIDEN NAME <i>Margaret Stream</i>	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	
16. SOCIAL SECURITY NO. <i>---</i>	17. INFORMANT <i>Wife C. F. Gregg, Burtonsville, Md.</i>	Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>445X</i>		INTERVAL BETWEEN ONSET AND DEATH <i>5 wk.</i>	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. <i>(b)</i>		Congestive heart failure	
DUE TO <i>(c)</i>		Arteriosclerotic heart disease	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Hypertensive cardiovascular disease</i>		19. WAS AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Dom. pleia, right</i>	
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ AM, from the causes and on the date stated above ADDRESS (Street, city or town, state) ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) <i>S. H. L. 1958</i>		DATE SIGNED <i>1/7/58</i>	
22a. BURIAL, CREMATION, BURIAL SPECIFY <i>Burial</i>	22b. DATE THEREOF <i>June 9 1958</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Burtonsville, Union</i>	22d. LOCATION (City, town, or county) (State) <i>Burtonsville, Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Logan Barber</i>	ADDRESS <i>Burtonsville, Md.</i>	24a. REC'D BY REGISTRAR DATE <i>11 11 '58</i>	24b. REGISTRAR'S SIGNATURE <i>Alfred</i>



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06987

7012

CERTIFICATE OF DEATH

Reg. Dist. No.

PLACE OF DEATH a. COUNTY <i>Montgomery</i>		MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>b. County</i>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		c LENGTH OF STAY IN lb	c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Washington, D.C.</i>						
d NAME OF HOSPITAL (If not in hospital, give street address) Q. INSTITUTION <i>Suburban</i>		d STREET ADDRESS <i>4426 Hawthorne St.</i>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print)	First <i>Horley</i>	Middle <i>James</i>	Last <i>Haines</i>	4. DATE OF DEATH <i>June 5 1958</i>					
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>11/8/1882</i>	9. AGE (In years last birthday) <i>75 yrs.</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS Days <i>0</i>	Hours <i>0</i>	Min <i>0</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Certified Public Act. Government</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Government</i>		11. BIRTHPLACE (State or foreign country) <i>Virginia</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>			
13. FATHER'S NAME <i>Louis Haines</i>		14. MOTHER'S Maiden NAME <i>Letetia Beazley</i>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown) <i>no</i>		16. SOCIAL SECURITY NO. (If yes give war or date of service)		17. INFORMANT <i>C. Gordon Haines</i>		Address <i>1240 Lake Falls Road Baltimore, Maryland</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Heart.</i>		DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <i>myocardial damage.</i>		INTERVAL BETWEEN ONSET AND DEATH <i>1 hr.</i>					
DUE TO cause (a), stating the underlying cause last (c) <i>Coronary Thrombosis</i>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>19</i> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>M.D. 4301 48th Street, Wash. D.C.</i>		20f. (City or town) <i>Washington, D.C.</i>		(County) <i>D.C.</i>	(State) <i>Wash. D.C.</i>
21. I certify that I attended the deceased from <i>6/7/58</i> , 19 <i>58</i> , to <i>6/5</i> , 19 <i>58</i> , that I last saw the deceased alive on <i>6/5</i> , 19 <i>58</i> , and that death occurred at <i>12:30 AM</i> , from the causes and on the date stated above.				ADDRESS (Street, city or town, state) <i>M.D. 4301 48th Street, Wash. D.C.</i>		DATE SIGNED <i>6/7/58</i>			
ACTUAL SIGNATURE <i>Sherman A. Thomas</i>									
PHYSICIAN'S NAME (Type) <i>Sherman A. Thomas</i>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>6/7/58</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>Glenwood Cemetery</i>		22d. LOCATION (City, town, or county) <i>Washington, D.C.</i>		(State) <i>Wash. D.C.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>The & Hines</i>		ADDRESS <i>2901-14th NW Washington D.C.</i>		24a. REC'D BY REGISTRAR DATE <i>JUN 9 '58</i>		24b. REGISTRAR'S SIGNATURE <i>John J.</i>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 1 Filing No. 6-72-51 et
CERTIFICATE OF DEATH

66988

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <i>Baltimore - C.Z.</i>		b. COUNTY <i>Baltimore - C.Z.</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>		c. LENGTH OF STAY IN TB <i>43d. New St.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>P.O. Box 1639 Baltimore, C.Z.</i>		d. STREET ADDRESS <i>Arthur Glenn Nursing Inc. 88</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Arthur Glenn Nursing Inc. 88</i>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Sarah</i>		First	Middle	Last	4. DATE OF DEATH <i>E Ham</i>	Month	Day	Year	
5. SEX <i>F</i>		6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>10-25-78</i>	9. AGE (In years last birthday) <i>74 yrs.</i>	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <i>0</i>	Days <i>0</i>	Hours <i>0</i>	Min <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>NURSE</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>COLORADO</i>		12. CITIZEN OF WHAT COUNTRY/ <i>U.S.A.</i>			
13. FATHER'S NAME <i>Fillerton, James</i>		14. MOTHER'S MAIDEN NAME <i>Trujillo, Feliciana</i>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yer. no. or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Fighter - SAME AS ABOVE</i>		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>193.0</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		c. CAUSE OF DEATH <i>Cerebral Neoplasm</i>				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>912 Ellsworth Drive</i>		20f. (City or town) <i>San Diego</i>		(County) <i>San Diego</i>	(State) <i>Calif</i>
21. I certify that I attended the deceased from <i>June 6th, 1958</i> to <i>June 7th, 1958</i> , that I last saw the deceased alive on <i>June 6th, 1958</i> , and that death occurred at <i>11:45 A.M.</i> from the causes and on the date stated above.						ADDRESS (Street, city or town, state) <i>912 Ellsworth Drive</i>		DATE SIGNED	
ACTUAL SIGNATURE <i>Philip E. Jones</i>		M.D.							
PHYSICIAN'S NAME (Type) <i>Philip E. Jones</i>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>JUNE 12, 1958</i>		22c. NAME OF CEMETERY OR CREMATORIAL PARK <i>GREENWOOD MEMORIAL PARK</i>		22d. LOCATION (City, town, or county) <i>San Diego</i>		(State) <i>Calif</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Philip E. Jones</i>		ADDRESS <i>WASH, D.C.</i>		24a. REC'D BY REGISTRAR <i>JUN 10 '58</i>		24b. REGISTRAR'S SIGNATURE <i>DeLoach</i>			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2. *... h Crt. et*

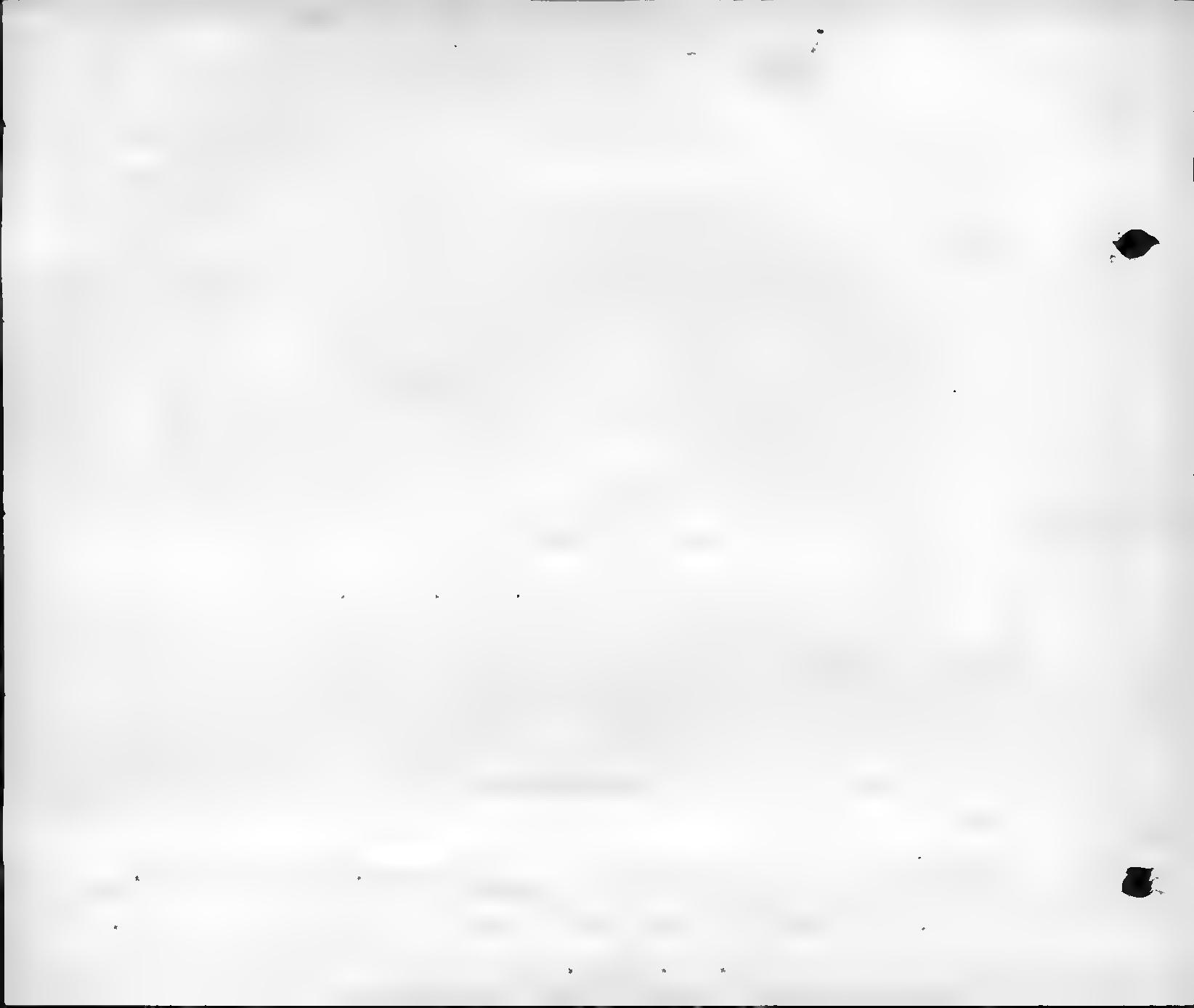
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6946

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived) If institution, Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Montgomery</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		c. LENGTH OF STAY IN b RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>		d. STREET ADDRESS <i>12512 Denley Road</i>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Washington Sanitarium + Hospital</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)		First <i>Infant</i>	Middle <i>Girl</i>	Last <i>Hankin</i>	4. DATE OF DEATH <i>June 28</i>	Month <i>June</i>	Day <i>28</i>	Year <i>1958</i>
5. SEX <i>Girl</i>		6. COLOR OR RACE <i>Jewish</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <i>June 28, 1958</i>	9. AGE (In years last birthday) yrs <i>3</i>	10. IF UNDER 1 YEAR Months <i>3</i>	11. IF UNDER 24 HRS Days <i>-</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>		
13. FATHER'S NAME <i>Coleman Robert Hankin</i>		14. MOTHER'S MIDDLE NAME <i>Lois Lichtenstein</i>		Address				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Mother's chart</i>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Prematurity</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last (b) <i>Congenital Atelectasis</i> DUE TO (c) <i>Passive Congestion, liver, spleen, brain</i>								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 16)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <i>7-28-58</i> , 1958, to <i>6-28-58</i> , 1958, that I last saw the deceased alive on <i>6-28</i> , 1958, and that death occurred at <i>7:44 AM</i> , from the causes and on the date stated above. ACTUAL SIGNATURE <i>J. J. Stroble</i>		ADDRESS (Street, city or town, state) <i>6-28-58</i> DATE SIGNED						
PHYSICIAN'S NAME (Type) <i>Stroble</i>		M.D.						
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Cremation</i>		22b. DATE THEREOF <i>6-30-58</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>Washington Sanitarium and Hospital</i>		22d. LOCATION (City, town, or county) <i>Takoma Park, Md.</i>		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert C. Hale, M.D.</i>		ADDRESS <i>Wash. San. & Hosp.</i>		24a. REC'D BY REGISTRAR <i>JUL 2 '58</i>		24b. REGISTRAR'S SIGNATURE <i>Ill. W. Edwards</i>		



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06990

7014

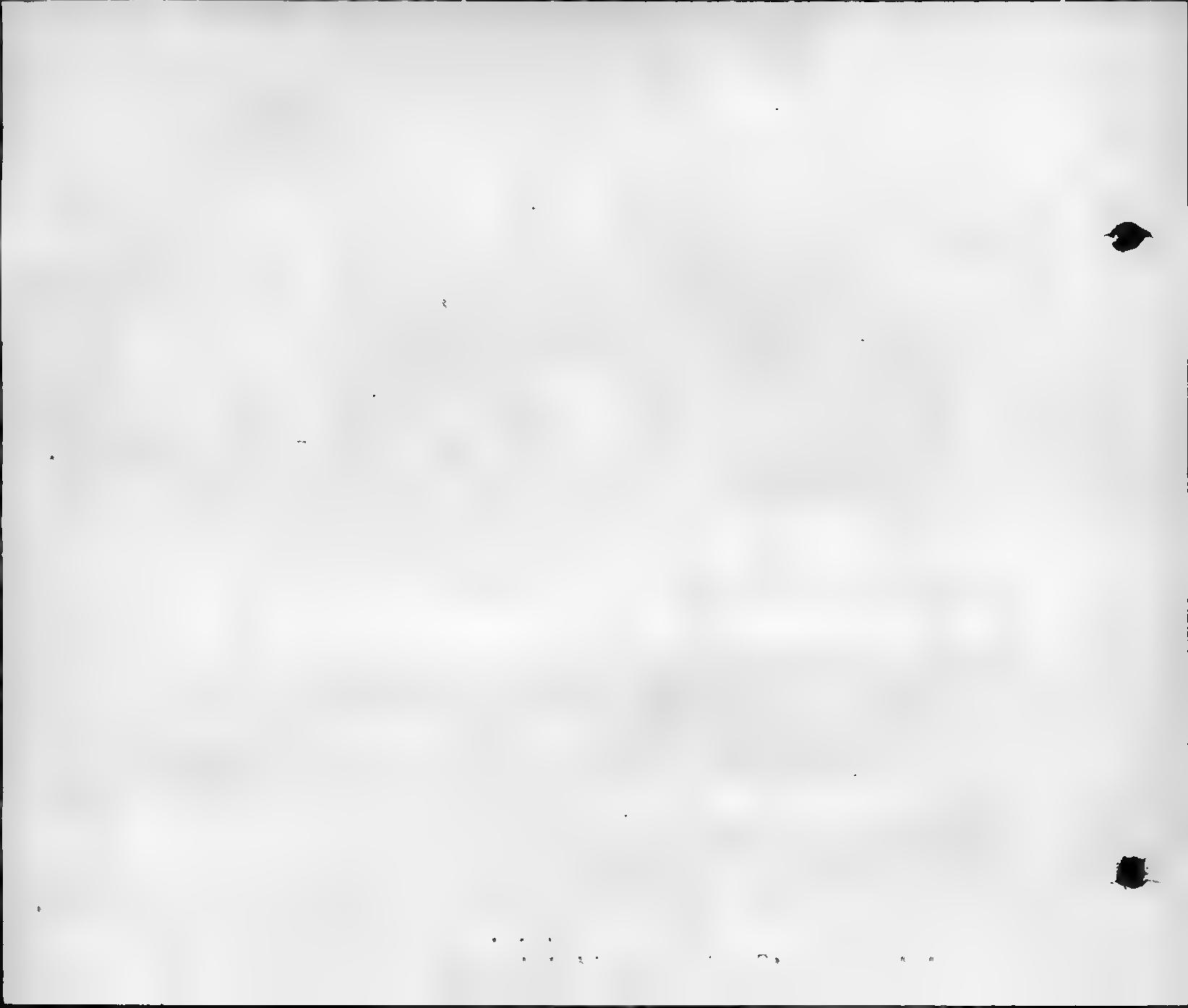
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>M.D.</u>		b. COUNTY <u>MONTGOMERY</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>		c. LENGTH OF STAY IN 1b <u>64 YEARS.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>		d. STREET ADDRESS <u>10022 FERNBROOK DRIVE</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>168 FERNBROOK TERRACE</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <u>FRED</u>		First	Middle <u>M.</u>	Last <u>HART</u>	4. DATE OF DEATH <u>JUNE 27 1958</u>	Month <u>JUNE</u>	Day <u>27</u>	Year <u>1958</u>
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>July 26, 1881</u>	9. AGE (in years last birthday) <u>76</u> yrs.	IF UNDER 1 YEAR <u>Months</u>	IF UNDER 24 HRS <u>Days</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cartographic Engineer</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		
13. FATHER'S NAME <u>Orson Edbert Hart</u>		14. MOTHER'S MAIDEN NAME <u>Harriet E. Fitch</u>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yrs. no. or unknown) <u>NO</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Rest Home Records - 168 Fleetwood Terrace</u> <u>Silver Spring, Md.</u>		Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>PULMONARY EMPHYSEMA AND FIBROSIS</u>						INTERVAL BETWEEN ONSET AND DEATH <u>4 YEARS.</u>		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>527.1</u>		DUE TO (b)						
		DUE TO (c)						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>8907 GEORGIA AVENUE</u>		20f. (City or town) <u>PRINCE GEORGES COUNTY</u>	(County)	(State)
21. I certify that I attended the deceased from <u>JUNE 27 1958</u> , and that I last saw the deceased alive on <u>JUNE 27 1958</u> , and that death occurred at <u>1 P.M.</u> from the causes and on the date stated above.						ADDRESS (Street, city or town, state) <u>SILVER SPRING, MARYLAND</u>		
ACTUAL SIGNATURE <u>James A. Roberts</u>		M.D.				DATE SIGNED <u>6/27/58</u>		
PHYSICIAN'S NAME (Type) <u>JAMES A. ROBERTS</u>								
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/30/1958</u>		22c. NAME OF CEMETERY OR CREMATORIUM <u>Cedar Hill Cemetery</u>		22d. LOCATION (City, town, or county) <u>Prince Georges County, Md.</u>		(State)
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Co. - 2901 14th St., N.W.</u>		ADDRESS <u>Wash. D.C.</u>		24a. REC'D BY REGISTRAR <u>MIN 30 '58</u>		24b. REGISTRAR'S SIGNATURE <u>John J. Smith</u>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-trust permit. Then please remove carbon papers. Pages 3 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 24 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-trust permit. Then please remove carbon papers. Pages 1 and 2 should be kept with the register prior to burial, cremation, or removal, and in any event within 72 hours after death.

Dr. Frank J. Broschart, MD, Montgomery County Medical Examiner notified.
U.S. Naval Hospital, Bethesda, Md. Instructed to handle in usual manner.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

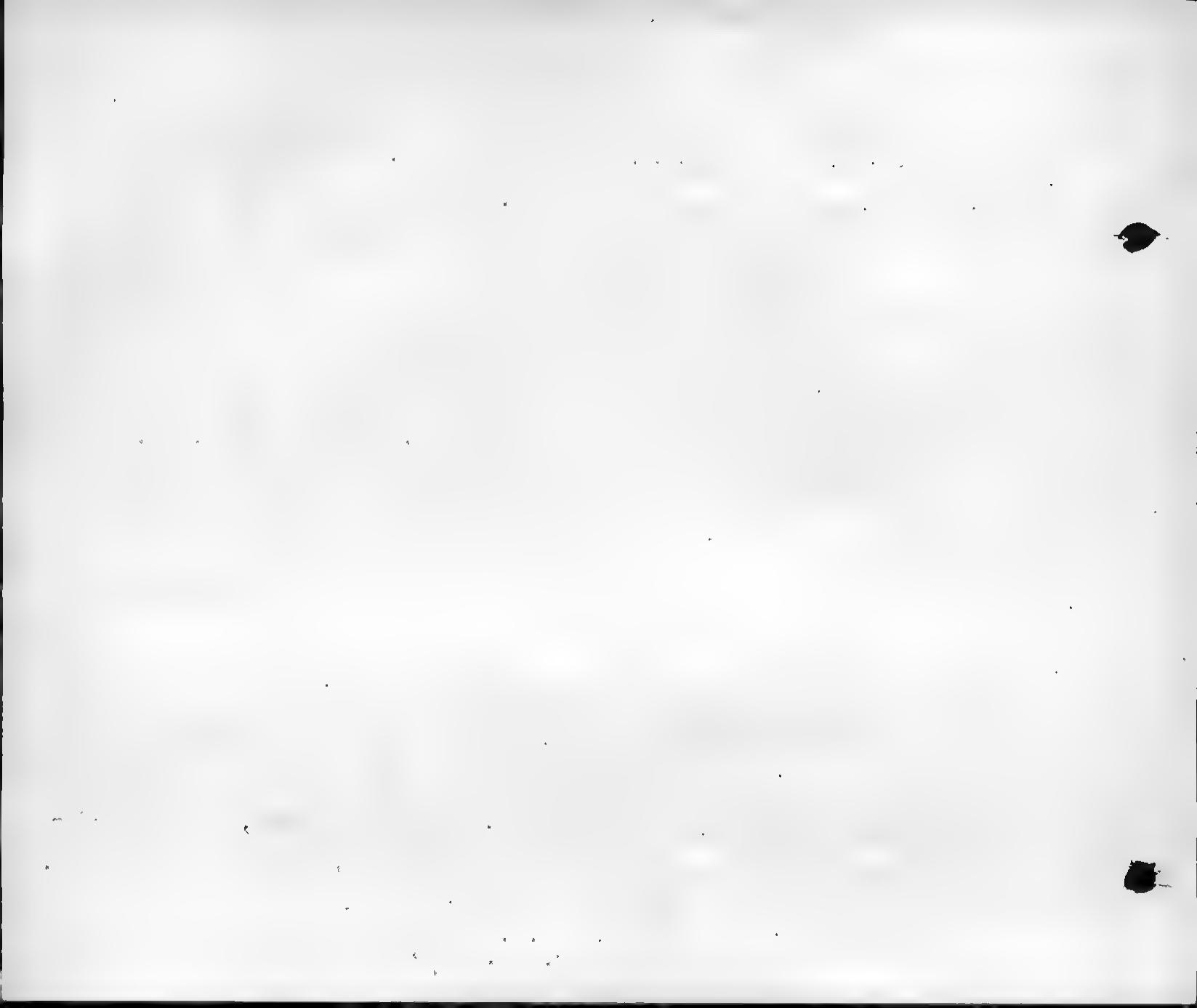
7015

CERTIFICATE OF DEATH

06991

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY Montgomery		2 USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b D.O.A.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) Ronald	First Lee	Middle HAYNES	4. DATE OF DEATH June 10 1958
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10 June 1958
9. AGE (in years from birthday) yrs. 13	10. IF UNDER 1 YEAR Months 13	11. IF UNDER 24 HRS Days 58	12. CITIZEN OF WHAT COUNTRY U.S.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY U.S.	
13. FATHER'S NAME Jack Lemon HAYNES		14. MOTHER'S MAIDEN NAME Patricia Annette MC CORMICK	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO None	
17. INFORMANT Father		Address St. Georges Island, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hyaline Membrane Disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pneumotitis DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH Unknown			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 10, 1958 to June 10, 1958 . That I last saw the deceased alive on June 10, 1958 , and that death occurred at 10:15 AM , from the causes and on the date stated above ADDRESS (Street, city or town, state) Irving B. KORETSKY DATE SIGNED 6-10-58			
ACTUAL SIGNATURE Irving B. KORETSKY, M.D. PHYSICIAN'S NAME (Type) LT MC USNR PATIENT'S NAME (Type) Patuxent River, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-13-58	
22c. NAME OF CEMETERY OR CREMATORIUM Ebenezer Cemetery		22d. LOCATION (City, town, or county) Great Mills, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Station Hospital, U.S.		24. REC'D BY REGISTRAR DATE JUN 16 1958	
Naval Air Station, Patuxent River, Md.		25. REGISTRAR'S SIGNATURE W. Schaefer	

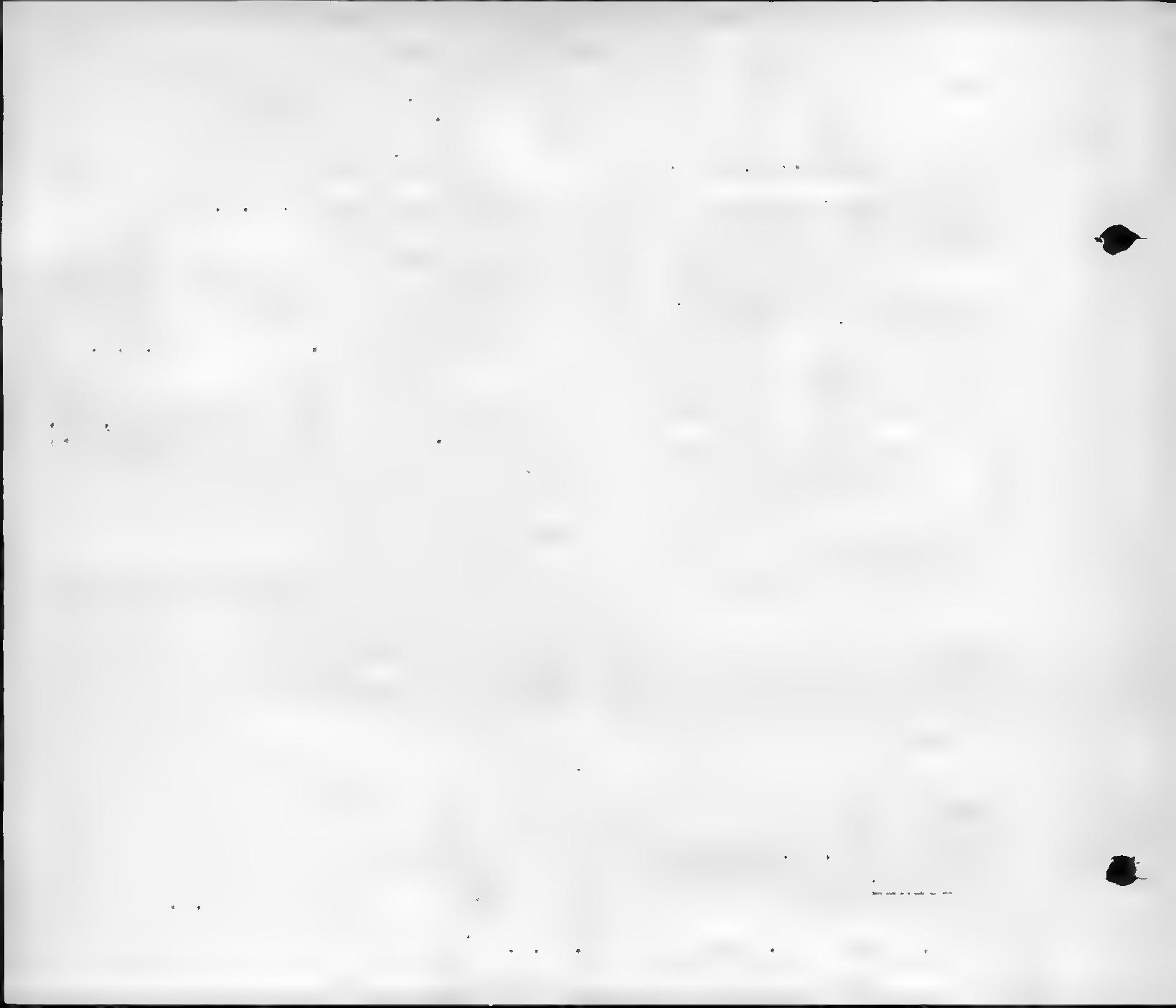


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the offending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in my event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 Item 14 Form 100 6-9-58 et
CERTIFICATE OF DEATH

Reg. Dist. No. 06992

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE D.C.		b. COUNTY	
b. C. T. Y. OR TOWN (If outside corporate limits, write RURAL and give nearest town) Argyle Club Rd., Layhill,		c. LENGTH OF STAY IN 1b RURAL		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington		d. STREET ADDRESS 1307 14th Street, N.W.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Seymour Nursing Home						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First DOROTHEA	Middle ROEDER	Last HEITMULLER	4. DATE OF DEATH	Month 6	Day 2	Year 1958
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH 3/14/1866	9. AGE (In years last birthday) yrs. 92	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS Days 0	Hours 0
8. WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Roeder				14. MOTHER'S MAIDEN NAME "Unobtainable"			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Stuart P. Heitmuller		Address Takoma Pk. Md. 804 Hudson Ave.,	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Myocarditis</i> <i>Hypertensive Cardio Vascular Disease</i>							
INTERVAL BETWEEN ONSET AND DEATH							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		(City or town) (County) (State)	
21. I certify that I attended the deceased from Jan , 19 58 , to June 2 , 19 58 , that I last saw the deceased alive on June 1 , 19 58 , and that death occurred at 7:00 M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Wm. F. Luckett</i>		ADDRESS (Street, city or town, state) 5000 Reno Rd NW					
PHYSICIAN'S NAME (Type) Wm. F. Luckett		DATE SIGNED 6-2-58					
22a. BURIAL/CREMATION REMOVAL (Check one) burial		22b. DATE THEREOF 6/6/58		22c. NAME OF CEMETERY OR CREMATORIUM Glenwood Cemetery		22d. LOCATION (City, town, or county) Washington, D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co., 2901 14th St. N.W.		ADDRESS Wash. D.C.		24a. REC'D BY REGISTRAR JUN 5 '58		24b. REGISTRAR'S SIGNATURE <i>Abigail Smith</i>	



1 D

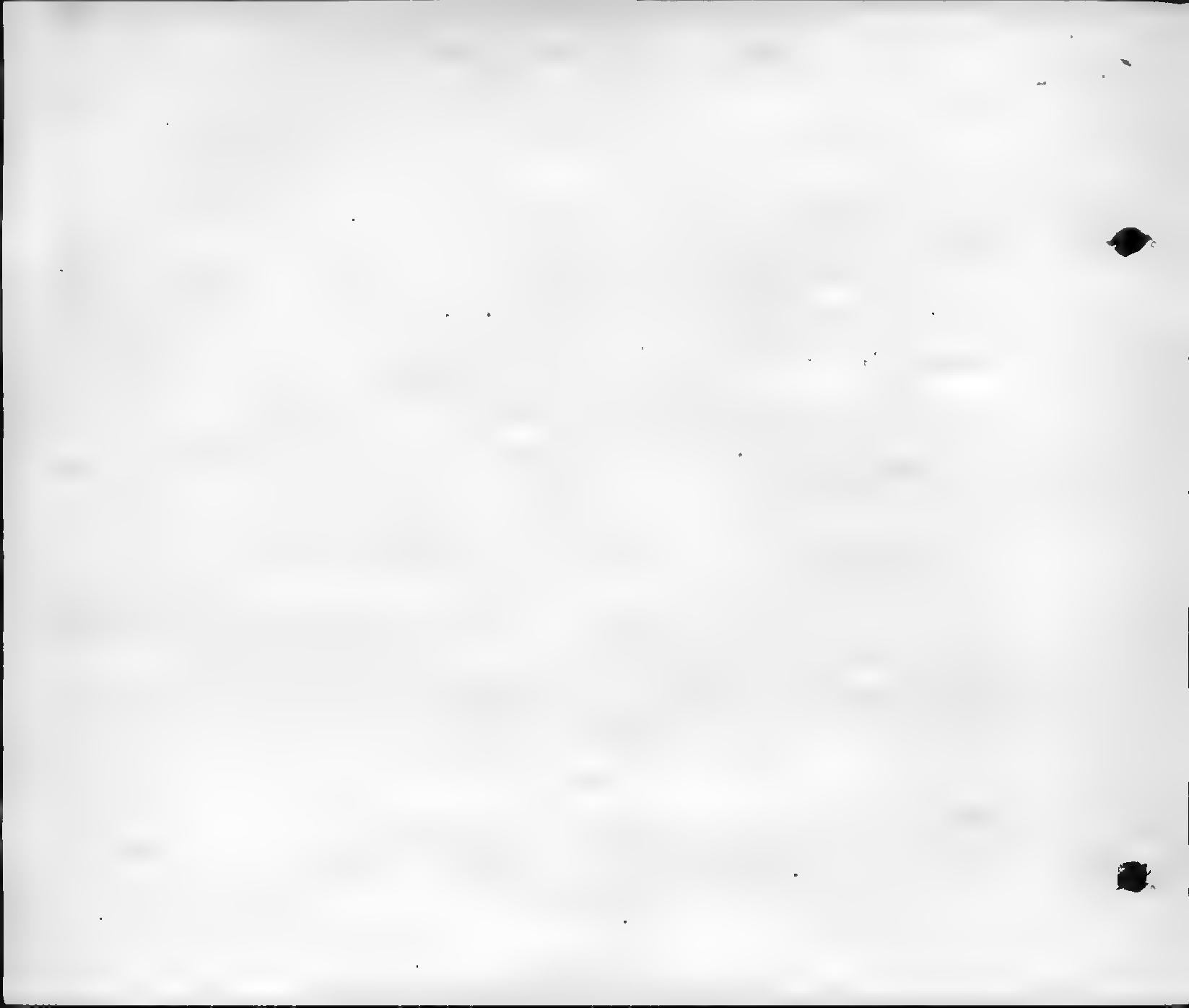
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06993

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enter the certificate, writing the word "Pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PAD. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-trunk permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)	
Montgomery				a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN TB		b. COUNTY Montgomery	
Bethesda					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		4605 Maple Avenue		e. IS RESIDENT ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
4605 Maple Avenue					
3. NAME OF DECEASED (Type or print)		First	Middle	4. DATE OF DEATH	Month
THOMAS		ALVIN	HERRING	June	2 19 58
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH	9. AGE (In years from birthday)
Male		White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	Dec. 5, 1875	82 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Conductor, ret.		Got it		Virginia	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME			
Unknown		Unknown			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
Yes Spanish Am.		None		Nancy L. Herring same as # 2d	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		Address			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		Coronary occlusion			
420.1					
DUE TO					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b)	Hypertension		
		(c)			
years					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
19					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
EXAMINER'S NAME (Type)		DATE SIGNED 6/2/58			
Frank J. Broschart, MD					
22a. BURIAL/CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIUM	
Burial		6/4/58		Ft. Lincoln	
23. FUNERAL DIRECTOR'S SIGNATURE		22d. LOCATION (City, town, or county) (State) Suitland, Maryland			
Robert A. Pumphrey Bethesda, Maryland		24a. REC'D BY REGISTRAR DATE JUN 4 1958			
		24b. REGISTRAR'S SIGNATURE John A. Smith			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06994

7018

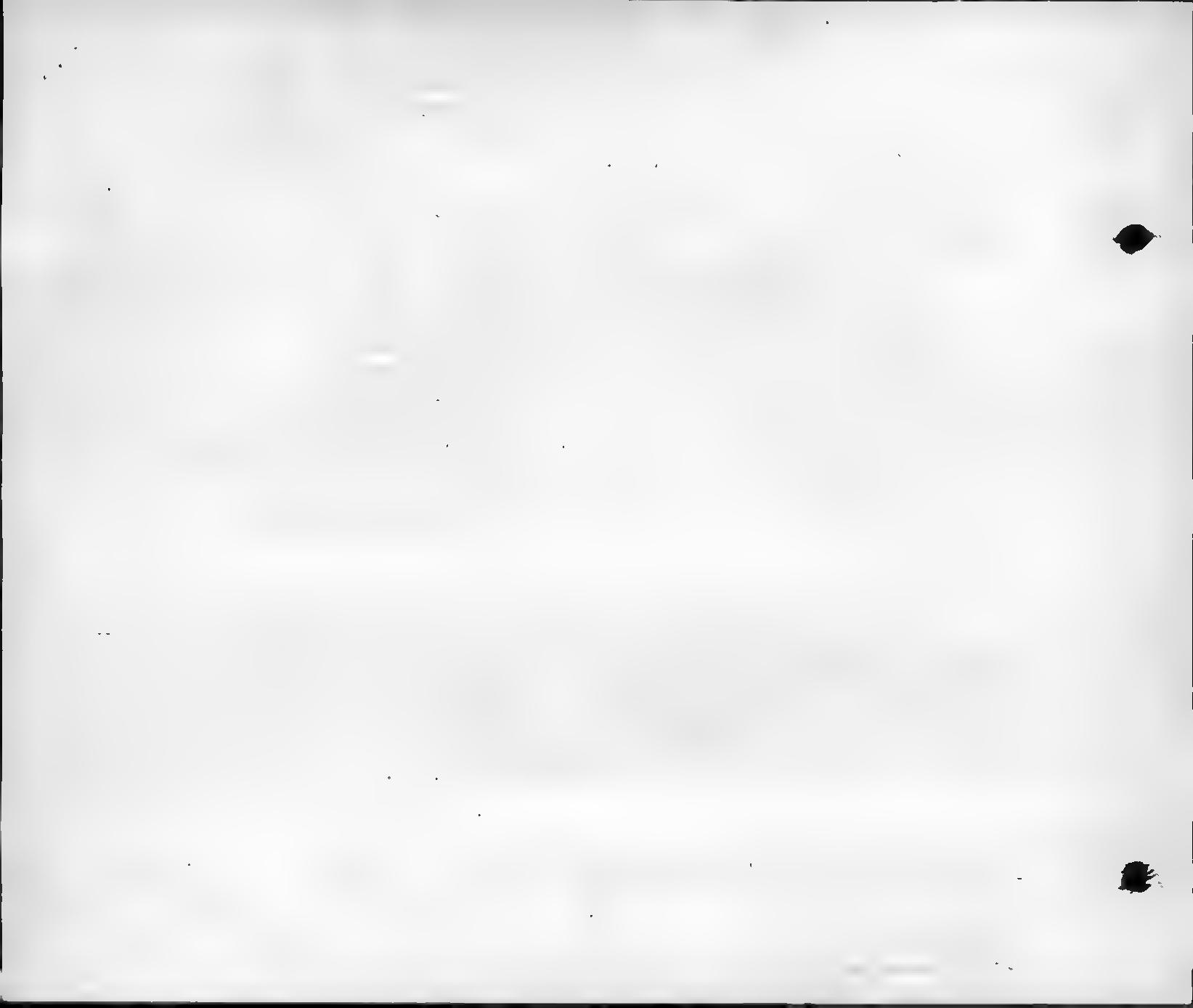
CERTIFICATE OF DEATH

Reg. Dist. No. 215

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of the death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached from the certificate and given to the funeral director. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Virginia		b. COUNTY	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c LENGTH OF STAY IN 1b 2yr. lmo. 27days		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North Arlington			
d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Maryland		d. STREET ADDRESS 4513 20th Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print)	First Charles	Middle Joseph	Last HOLEMAN	4 DATE OF DEATH June	Month 21	Day 19	Year 58
5. SEX Male	6 COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 14 March 1880	9. AGE (In years last birthday) 78 yrs	IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Physician		10b. KIND OF BUSINESS OR INDUSTRY U.S. Navy Retired		11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY U.S.	
13. FATHER'S NAME William HOLEMAN		14. MOTHER'S MAIDEN NAME Hannah SHEPHERD					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes	16. SOCIAL SECURITY NO. WW-I	17. INFORMANT (Wife) Mrs. Priscilla M. HOLEMAN (Same As #2)		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Hypertensive Pneumonitis</i> DUE TO <i>33IX</i> INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Cerebrovascular Accident</i> DUE TO <i>6 mos</i> (c) <i>Generalized Arteriosclerosis</i> DUE TO <i>unk -</i>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that I attended the deceased from 24 April 1956, to 21 June 1958, that I last saw the deceased alive on 21 June 1958, and that death occurred at 9:30A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>T.S. Dunn Jr.</i>		ADDRESS (Street, city or town, state) M.D. U.S. Naval Hospital, Bethesda, Md. 6-21-58					
DATE SIGNED							
PHYSICIAN'S NAME (Type) T.S. DUNN, JR. LT, USA, MC, USN		U.S. Naval Hospital, Bethesda, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 6-25-58	22c. NAME OF CEMETERY OR CREMATORIUM Arlington Nat'l Cemetery		22d. LOCATION (City, town, or county) Arlington, Virginia		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE R. A. CUMMINGS		ADDRESS Wisconsin Ave., Bethesda, Md.		24a. REC'D BY REGISTRAR DATE 24 58	24b. REGISTRAR'S SIGNATURE <i>Orrell</i>		



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7 Film 0231 7-3-58 et

06995

7019

CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The form requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH o COUNTY Montgomery		MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) o STATE Maryland		b COUNTY Montgomery	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 4 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase		d. STREET ADDRESS 3604 Shepherd Street	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) Ella		First M. Middle		Last		4 DATE OF DEATH Month June Day 25, Year 1958	
5 SEX Female		6. COLOR OR RACE White		7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6/1/1873	
9 AGE (In years last birthday) 85 yrs		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Housewife		11 BIRTHPLACE (State or foreign country) Ohio	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Edward Martin		14 MOTHER'S MAIDEN NAME Unknown.		Address Mr. James C. Hilland Son Same	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Tel. no. or unknown) No		16. SOCIAL SECURITY NO 44-3-0		17. INFORMANT Congestive Heart Failure		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Arteriosclerotic heart disease	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. b.		DUE TO Arteriosclerotic heart disease		DUE TO c.		INTERVAL BETWEEN ONSET AND DEATH 16 days	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work o. m. 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) MD 8016 Georgetown Rd 20f. (City or town) (County) Rockville (State) Md	
21. I certify that I attended the deceased from June 25, 1958 to June 25, 1958 that I last saw the deceased alive on June 25, 1958 , and that death occurred at 2:45 P.M. from the causes and on the date stated above				ADDRESS (Street, city or town, state) 8016 Georgetown Rd		DATE SIGNED 6/25/58	
ACTUAL SIGNATURE Leo Donovan		PHYSICIAN'S NAME (Type) Leo Donovan		22c. NAME OF CEMETERY OR CREMATORIUM Parklawn		22d. LOCATION (City, town, or county) Rockville, Md. (State)	
22a. BURIAL CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 6/28/58		22c. NAME OF CEMETERY OR CREMATORIUM Parklawn		22d. LOCATION (City, town, or county) Rockville, Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Maryland		ADDRESS		24a. REC'D BY REGISTRAR JUN 27 '58		24b. REGISTRAR'S SIGNATURE Robert A. Pumphrey	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7020

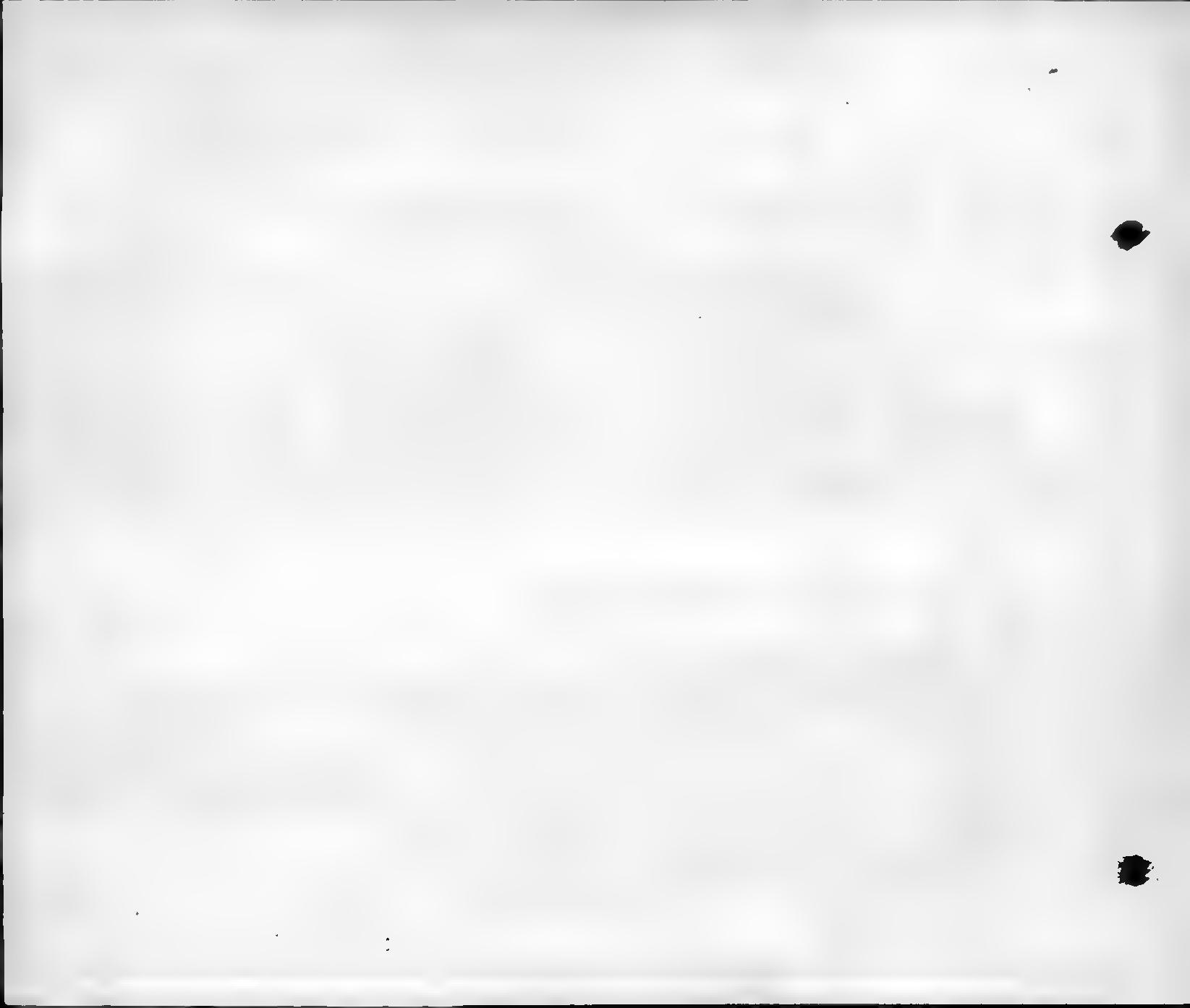
CERTIFICATE OF DEATH

06996

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY MONTGOMERY		2. USUAL RESIDENCE (Where deceased lived) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. LENGTH OF STAY IN 1b 2 YEARS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MAPLE LANE NURSING HOME		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING	
f. STREET ADDRESS 9810 GEORGIA AVENUE		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) SARAH		First B	Middle HOLLAND
4. DATE OF DEATH JUNE 19 1958		Month JUNE	Day 19
5. SEX FEMALE		6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH 6/18/1874		9. AGE (In years last birthday) 84 yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) WASHINGTON, D. C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME DAVID S. HOLLAND		14. MOTHER'S MAIDEN NAME MARY E. HUTTON	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT T. STANLEY HOLLAND, SOMERSET, MARYLAND		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HYPERTENSIVE HEART DISEASE DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause (last) } (b) GENERALIZED ARTERIOSCLEROSIS DUE TO (c) ESSENTIAL HYPERTENSION			
INTERVAL BETWEEN ONSET AND DEATH			
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) SEALITIS			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour G. M. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from JUNE 29, 1958 , to JUNE 19, 1958 , that I last saw the deceased alive on JUNE 19, 1958 , and that death occurred at 11:15 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 5206 NORWAY DR. CHEVY CHASE, MD			
ACTUAL SIGNATURE <i>Henry M. Lowden</i>		DATE SIGNED 4/19/58	
PHYSICIAN'S NAME (Type) HENRY M. LOWDEN			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 6/21/58	
22c. NAME OF CEMETERY OR CREMATORIUM ROCK CREEK CEMETERY		22d. LOCATION (City, town, or county) WASHINGTON, D. C.	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Jackie Hawley Sonne, 1256 1/2, Inc. Rockville</i>		24a. REC'D. BY REGISTRAR JUN 23 1958	
		24b. REGISTRAR'S SIGNATURE <i>Orville Beck</i>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7021

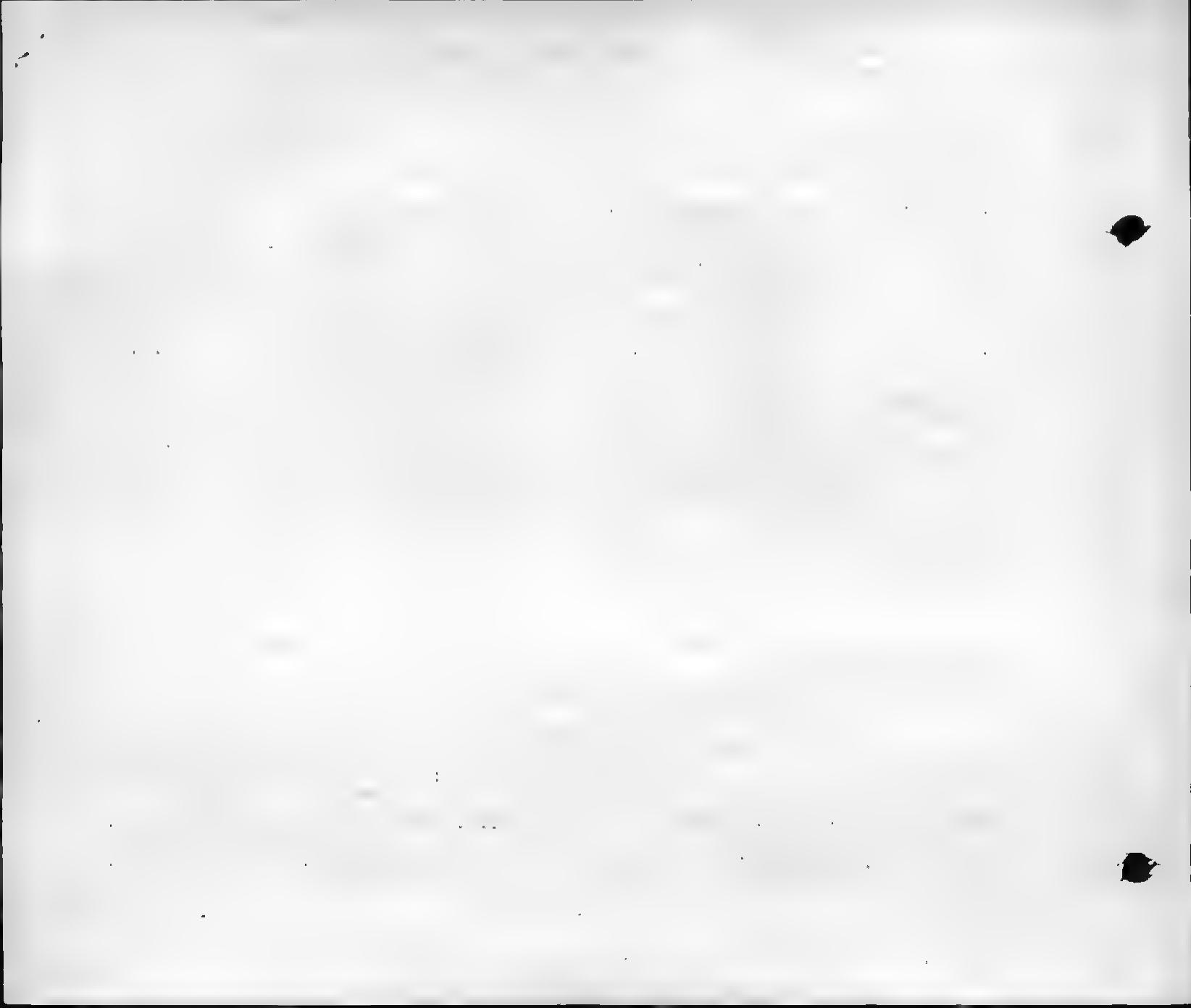
CERTIFICATE OF DEATH

Reg. Dist. No.

06097

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death: Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours of death.

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 1 Month 3 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.		d. STREET ADDRESS 110 Market Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Hiester	Middle (n)	Last HOOGEWERFF	4. DATE OF DEATH June 8 1958	Month	Day	Year
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 4-19-92	9. AGE (In years last birthday) 66	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. Navy		10b. KIND OF BUSINESS OR INDUSTRY U.S. Navy		11. BIRTHPLACE (State or foreign country) District of Columbia		12. CITIZEN OF WHAT COUNTRY U.S.	
13. FATHER'S NAME John Adriaan HOOGEWERFF				14. MOTHER'S MAIDEN NAME Edwardine HIESTER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or date of service) Yes		16. SOCIAL SECURITY NO. Class 1912 WWII Unknown		17. INFORMANT Mrs. Mary-Safford HOOGEWERFF (Same as #2)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease INTERVAL BETWEEN ONSET AND DEATH Undetermined							
Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b)		DUE TO					
(c)		DUE TO					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 5-8-1958 , to 6-8-1958 , that I last saw the deceased alive on 6-8-1958 , and that death occurred at 6:40A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <i>F. S. Caldwell</i> M.D. U.S. Naval Hospital, Bethesda, Md. 6-9-58							
PHYSICIAN'S NAME (Type)		F. S. CALDWELL, LT, MC, USN		U.S. Naval Hospital, Bethesda, Md.			
22a. BURIAL, CREMATION OR REMOVAL (Specify) Burial		22b. DATE THEREOF 6-11-58		22c. NAME OF CEMETERY OR CREMATORIUM Naval Academy Cemetery		22d. LOCATION (City, town, or county) Annapolis, Maryland (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John M. Taylor</i>		ADDRESS Annapolis, Maryland		24a. REC'D BY REGISTRAR DATE JUN 10 1958		24b. REGISTRAR'S SIGNATURE <i>W. L. Eadie</i>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

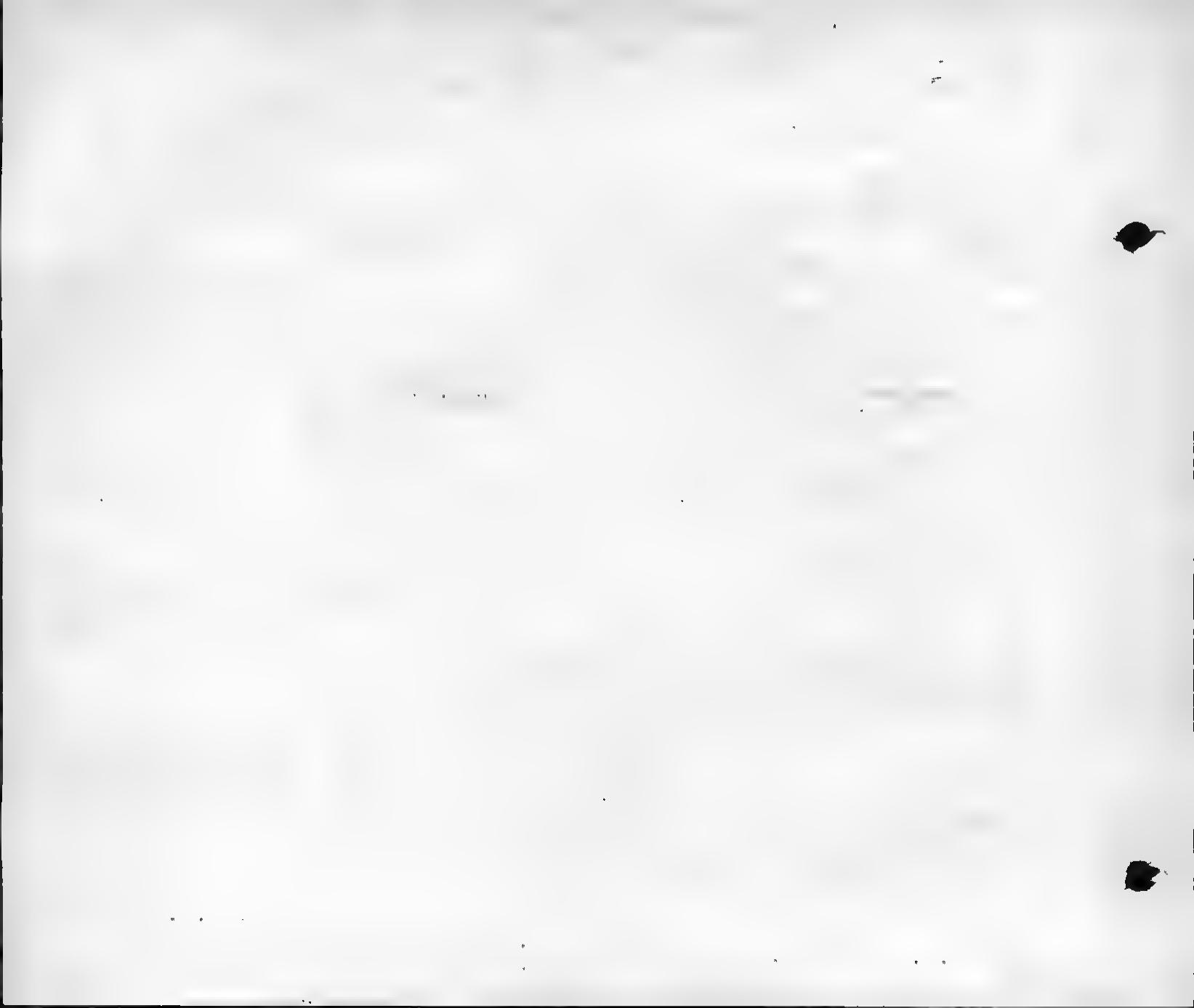
06998

6947

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		b. COUNTY <i>Montgomery</i>	
c. LENGTH OF STAY IN 1b <i>1-5-58 to 6-26-58</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Chevy Chase</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Washington Sanitorium & Hospital</i>		d. STREET ADDRESS <i>2909 Daniel Road</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Gertrude Chadsey Houston</i>		4. DATE OF DEATH <i>June 26 1958</i>	Month Day Year
5. SEX <i>Female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>11-4-71</i>
9. AGE (In years at birthday) <i>86 yrs</i>		10. IF UNDER 1 YEAR Months Days Hours Min	11. IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Government employee</i>		11. BIRTHPLACE (State or foreign country) <i>Washington D.C.</i>	
12. CITIZEN OF WHAT COUNTRY? <i>Amer.</i>			
13. FATHER'S NAME <i>Sam Houston</i>		14. MOTHER'S MAIDEN NAME <i>Margaret Waidley</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) <i>No</i>		16. SOCIAL SECURITY NO <i>Hosp. fat Record</i>	
17. INFORMANT <i>Hospital Record</i>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Medicardiac Thrombosis of coronary arteries</i>		INTERVAL BETWEEN ONSET AND DEATH <i>5 years</i>	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. <i>170X</i>			
(b)			
DUE TO Cause (c)			
Part II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>July 7, 1958</i> to <i>June 26, 1958</i> that I last saw the deceased alive on <i>June 25, 1958</i> , and that death occurred at <i>4:12 PM</i> , from the causes and on the date stated above. ACTUAL SIGNATURE <i>Harry N. Carlton</i> ADDRESS (Street, city or town, state) <i>1816 R Street, N.W.</i> DATE SIGNED <i>June 26, 1958</i> PHYSICIAN'S NAME (Type) <i>Harry N. Carlton</i> 1816 R Street, N.W.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>burial</i>		22b. DATE THEREOF <i>6/28/58</i>	
22c. NAME OF CEMETERY OR CREMATORIUM <i>Rock Creek Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Washington, D.C.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co.		24a. REC'D. BY REGISTRAR <i>JUN 30 1958</i>	
		24b. REGISTRAR'S SIGNATURE <i>John J. Hines</i>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7022

CERTIFICATE OF DEATH

06999

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		c. LENGTH OF STAY IN b 49hrs 48m		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) n. x Beallsville		d. STREET ADDRESS /			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery County General Hospital				d. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First Sharon	Middle Kay	Last Howard	4. DATE OF DEATH June	Month June	Day 8	Year 1958		
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 6, 1958	9. AGE (In years lost birthday) yrs. 1	10. IF UNDER 1 YEAR Months 1	11. IF UNDER 24 HRS Days 48	12. IF UNDER 24 HRS Hours 1		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none (baby)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY/ United States			
13. FATHER'S NAME Edward Howard				14. MOTHER'S MAIDEN NAME Catherine Howard					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) none		16. SOCIAL SECURITY NO.		17. INFORMANT Catherine Howard		Address Beallsville, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Hereditary Disease</i> INTERVAL BETWEEN ONSET AND DEATH <i>xt 18 m</i>									
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) <i></i>									
DUE TO DUE TO (c) <i></i>									
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Hour a. p.m. p. m.	Month 19	Day	Year	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not white of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <i>b16</i>	(County) <i>618</i>	(State) <i>1958</i>	
21. I certify that I attended the deceased from <i>6/6 1958</i> to <i>6/8 1958</i> , that I last saw the deceased alive on <i>6/7 1958</i> , and that death occurred at <i>7:40 A.M.</i> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>Sandy Spring, Maryland</i>								DATE SIGNED <i>6/11/58</i>	
ACTUAL SIGNATURE <i>Dr. Charles H. Ligon</i>									
PHYSICIAN'S NAME (Type) Dr. Charles H. Ligon									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 6/10/58	22c. NAME OF CEMETERY OR CREMATORIUM Boyd's Presbyteries	22d. LOCATION (City, town, or county) Boyd's	(State) <i>Md.</i>					
23. FUNERAL DIRECTOR'S SIGNATURE <i>Constance C. Helton</i>	ADDRESS <i>Barnesville, Md.</i>	24a. REC'D BY REGISTRAR DATE JUN 11 '58	24b. REGISTRAR'S SIGNATURE <i>Alt. eschut</i>						

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the Burial-Death permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7023

CERTIFICATE OF DEATH

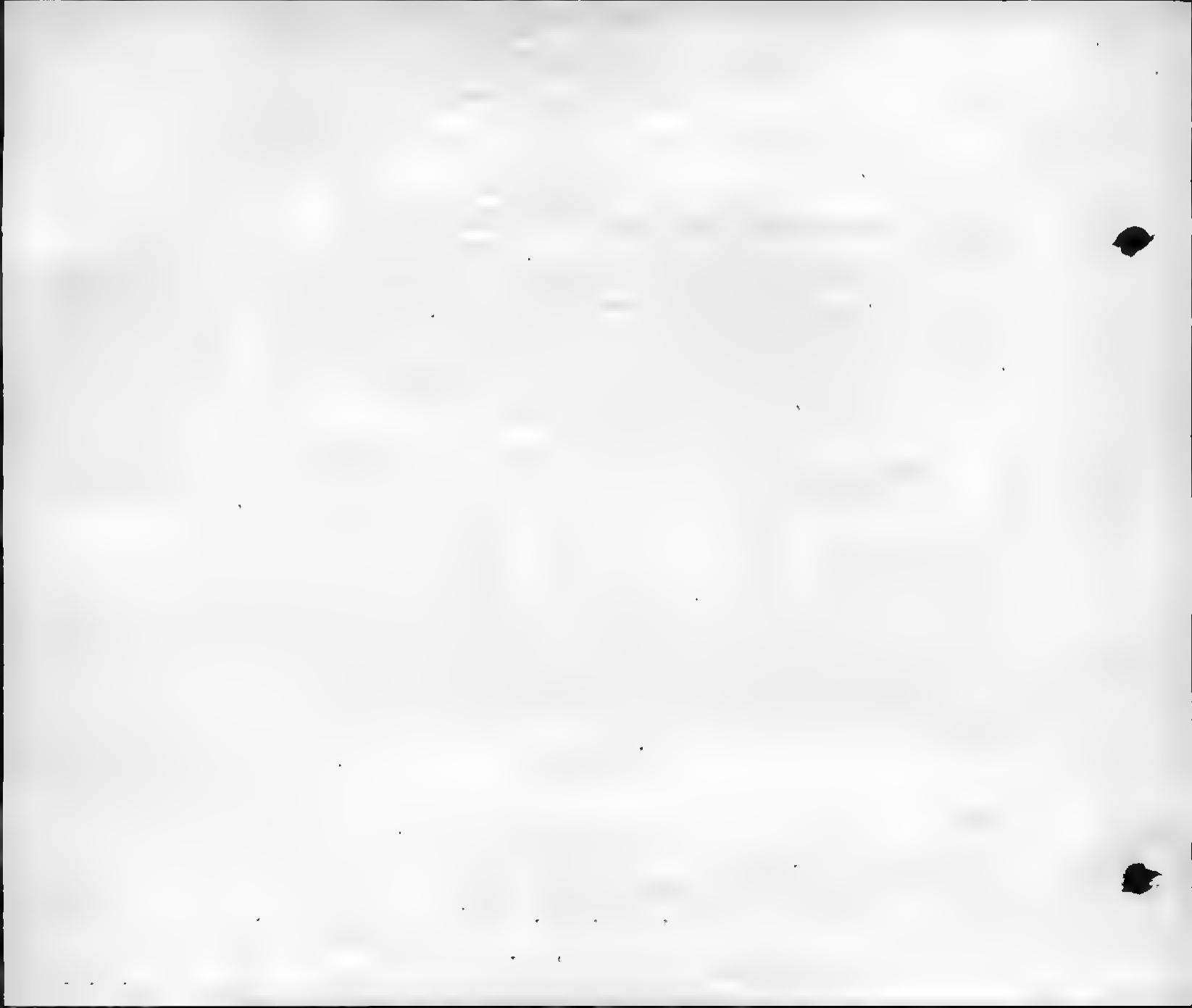
07000

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)					
Montgomery		MARYLAND		a. STATE	b. COUNTY				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)					
Bethesda		11 days		SILVER SPRING 56					
d. NAME OF HOSPITAL (If not in hospital, give street address or institution)		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
Suburban Hospital		1816 Brisbane St.							
3. NAME OF DECEASED (First, Middle, Last)		4. DATE OF DEATH		Month Day Year					
Bernard Elton Hynson		JUN 30		1958					
5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>					
Male white		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH					
9. AGE (In years last birthday)		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY	
53 yrs		PAINTER-contractor		Own business		VIRGINIA		U.S.A.	
13. FATHER'S NAME		14. MOTHER'S MARRIED NAME		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO		17. INFORMANT	
Glenn Hynson		Laura Bell Lampkin		No		214-12-7649		Doro Thy Hynson 1816 Brisbane St. Silver Spring 55	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		DUE TO		CORONARY INSUFFICIENCY		INTERVAL BETWEEN ONSET AND DEATH	
420.1		Subendoocardial + Posterior Myocardial Infarction		DUE TO		CORONARY ARTERIOSCLEROSIS			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first.		(b)		(c)					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from _____ to _____, that I last saw the deceased alive on _____, and that death occurred at _____, from the causes and on the date stated above.									
ACTUAL SIGNATURE		M.D.		ADDRESS (Street, city or town, state)		DATE SIGNED			
PHYSICIAN'S NAME (Type)		WILLIAM D. AUD		900 Lebowelle Rd. Silver Spring 55		7/1/58			
22e. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIUM		22d. LOCATION (City, town, county)		(State)	
BURIAL		7/3/58		GEO. WASH. MEM. CEMETERY		PRINCE GEO. COUNTY, MARYLAND			
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D. BY REGISTRAR DATE		24b. REGISTRAR'S SIGNATURE			
Warren E. Humphrey		SILVER SPRING, MD.		JUL 7 '58		A. Smith			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7024

CERTIFICATE OF DEATH

Reg. Dist. No. 07001

1. PLACE OF DEATH a. COUNTY Montgomery		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Poolesville		c. LENGTH OF STAY IN lb 27 yrs		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Montgomery	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Poolesville		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) John Wesley Imes		First	Middle	Last	4. DATE OF DEATH June 9 1958	Month	Day	Year	
5. SEX Male		6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH April 8, 1874	9. AGE (In years at birthday) 84 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days	Hours	Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Jack Imes		14. MOTHER'S MAIDEN NAME Elizabeth Murphy							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO		17. INFORMANT Emma Imes 226 N. Washington St., Rockville, Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebro Vascular Accident 445X		DUE TO (b) Hypertension-Arteriosclerosis		Cardiovascular Disease (c)		INTERVAL BETWEEN ONSET AND DEATH 20 hours			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) (c)									
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Boyd, Md.		20f. (City or town) Boyd, Md.		(County)	(State)
21. I certify that I attended the deceased from _____ alive on _____ and that death occurred at _____, from the causes and on the date stated above.						ADDRESS (Street, city or town, state) Boyd, Md.		DATE SIGNED 12 June 58	
ACTUAL SIGNATURE John W. Smiths		PHYSICIAN'S NAME (Type) Robert L. Saundee							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/13/58		22c. NAME OF CEMETERY OR CREMATORIAL Martinsburg, Md.		22d. LOCATION (City, town, or county) Martinsburg, Md.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Robert L. Saundee		ADDRESS Rockville, Md.		24a. REC'D BY REGISTRAR JUN 16 '58		24b. REGISTRAR'S SIGNATURE Alfred Smith			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



07002

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
7025 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PMJ. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a Burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1		Reg. Dist. No. _____											
1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)											
a. COUNTY		a. STATE _____ b. COUNTY _____											
Montgomery		Md. Montg.											
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)											
Bethesda		Bethesda											
c. LENGTH OF STAY IN 1b		d. STREET ADDRESS											
12 yrs		8225 Custer Rd											
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		e. S. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
8225 Custer Rd													
3. NAME OF DECEASED (Type or print)		First		Middle		Last		4. DATE OF DEATH		Month Day Year			
Mary Reavis Jarboe						Jones		24		19 58			
5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years, to nearest birthday)		10. IF UNDER 1 YEAR OLD <input type="checkbox"/> IF UNDER 24 HRS			
Female		White		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8-11-1920		37 yrs		Months Days Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?							
Housewife				D.C.		U.S.A.							
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME											
Thomas H. Reavis		Rita Bourgeois											
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address		INTERVAL BETWEEN ONSET AND DEATH					
NO				Thomas H. Reavis		3305 Belair St Chevy Chase, Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Homicide</u> DUE TO <u>976x</u> Conditions, if any, which gave rise to immediate cause (b) <u>Shot gun wound in rt neck</u> stating the underlying cause last. DUE TO (c)											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)											
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20c. TIME OF INJURY Month, Day, Year Hour o. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
7 pm 6/24 1958		While at work <input checked="" type="checkbox"/>		Home		Bethesda Montg. Md.							
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE <u>Frank J. Broschart</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>										DATE SIGNED 6-24-58	
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>													
22a. BURIAL CREMATION REMOVAL (Specify) Burial		22b. DATE THEREOF 6/27/58		22c. NAME OF CEMETERY OR CREMATORIUM Parklawn		22d. LOCATION (City, town, or county) Rockville, Maryland		(State)					
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Maryland		24a. REC'D BY REGISTRAR DATE JUN 27 1958										24b. REGISTRAR'S SIGNATURE <u>Alfred Wink</u>	
VS AT 15ME 8M 2/57													



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

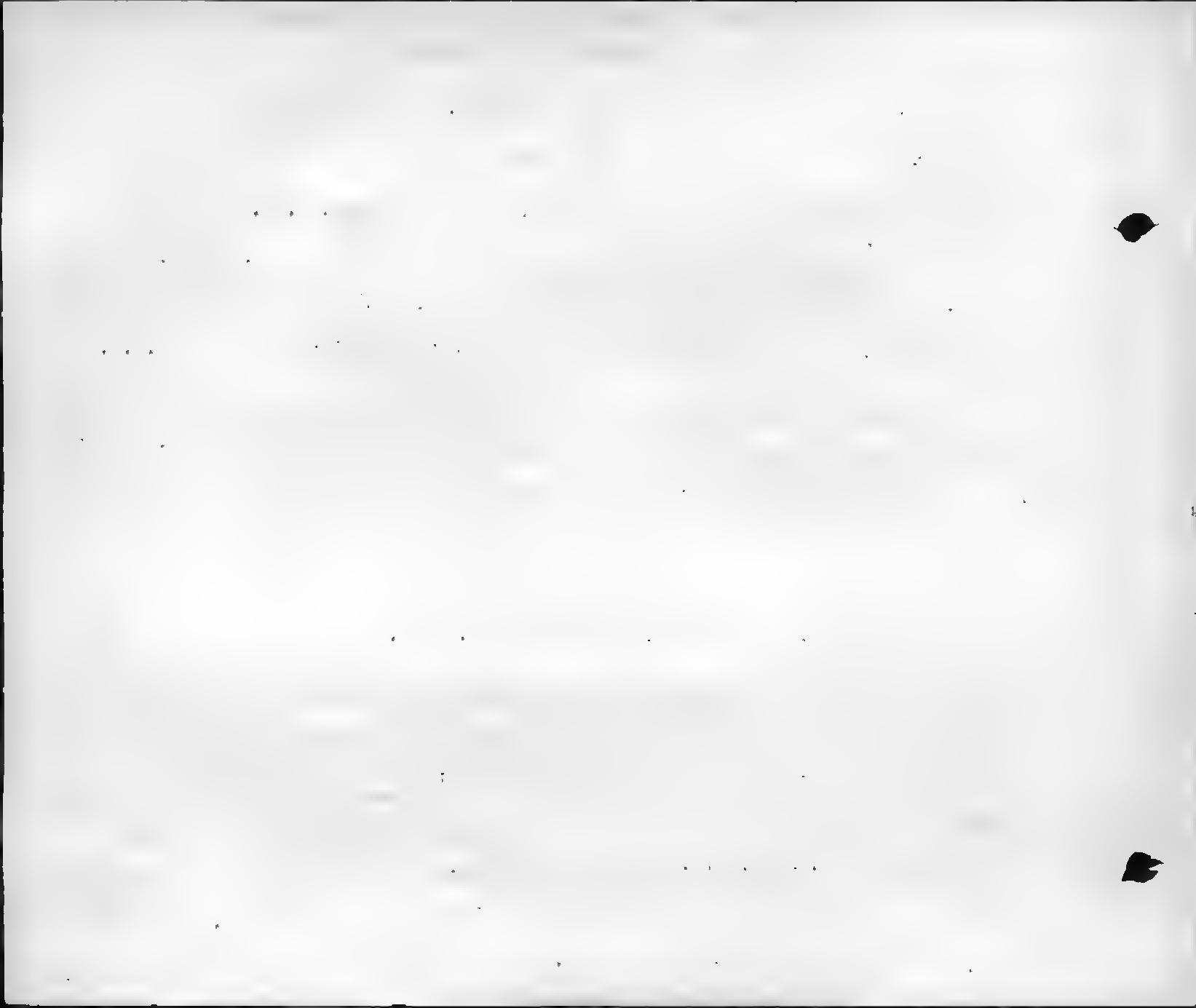
07003

7026

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) STATE District of Columbia		COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN lb 73 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center		d. STREET ADDRESS 11447 Cedar Street, S. E.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First John	Middle Edward	Last Jeter	4. DATE OF DEATH June 26th, 1958	Month	Day	Year
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH February 22, 1903	9. AGE (In years last birthday) 55 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dry Cleaner		10b. KIND OF BUSINESS OR INDUSTRY Dry Cleaning		11. BIRTHPLACE (State or foreign country) South Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Fair Jeter				14. MOTHER'S MAIDEN NAME Beulah Hampton			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) No		16. SOCIAL SECURITY NO Not available		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute lymphatic leukemia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) Lymphosarcoma DUE TO (c)							
INTERVAL BETWEEN ONSET AND DEATH 2 months							
4 years							
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Septicemia, Staphylococcus aureus and E. coli.							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
MEDICAL CERTIFICATION		20. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from April 11th, 1958 to June 26th, 1958 that I last saw the deceased alive on June 26th, 1958 , and that death occurred at 8:00 AM from the causes and on the date stated above. ADDRESS (Street, city or town, state) Kurt W. Kohn, M.D.							
ACTUAL SIGNATURE <i>Kurt W. Kohn</i>		DATE SIGNED 6/26/58					
PHYSICIAN'S NAME (Type) Kurt W. Kohn, M.D.		M.D. The Clinical Center The National Institutes of Health Bethesda 14, Maryland					
22a. BURIAL, Cremation REMAINS RECENTLY		22b. DATE THEREOF 7/1/58		22c. NAME OF CEMETERY OR CREMATORIUM Lincoln Memorial Cemetery		22d. LOCATION (City, town, or county) Suitland Md.	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Ed. Ernest Jarvis</i>		ADDRESS 21432 You St. NW		24a. REC'D BY REGISTRAR JUL 2 '58		24b. REGISTRAR'S SIGNATURE <i>Albert L. Smith</i>	
VS A15 (4) 15M 10/57							



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "Pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Pages 4 should be forwarded to the Chief Medical Examiner's Office along with Part I of the certificate. File pages 1 and 2 with the State Board of Health. File pages 3 and 2 with the State Board of Health.

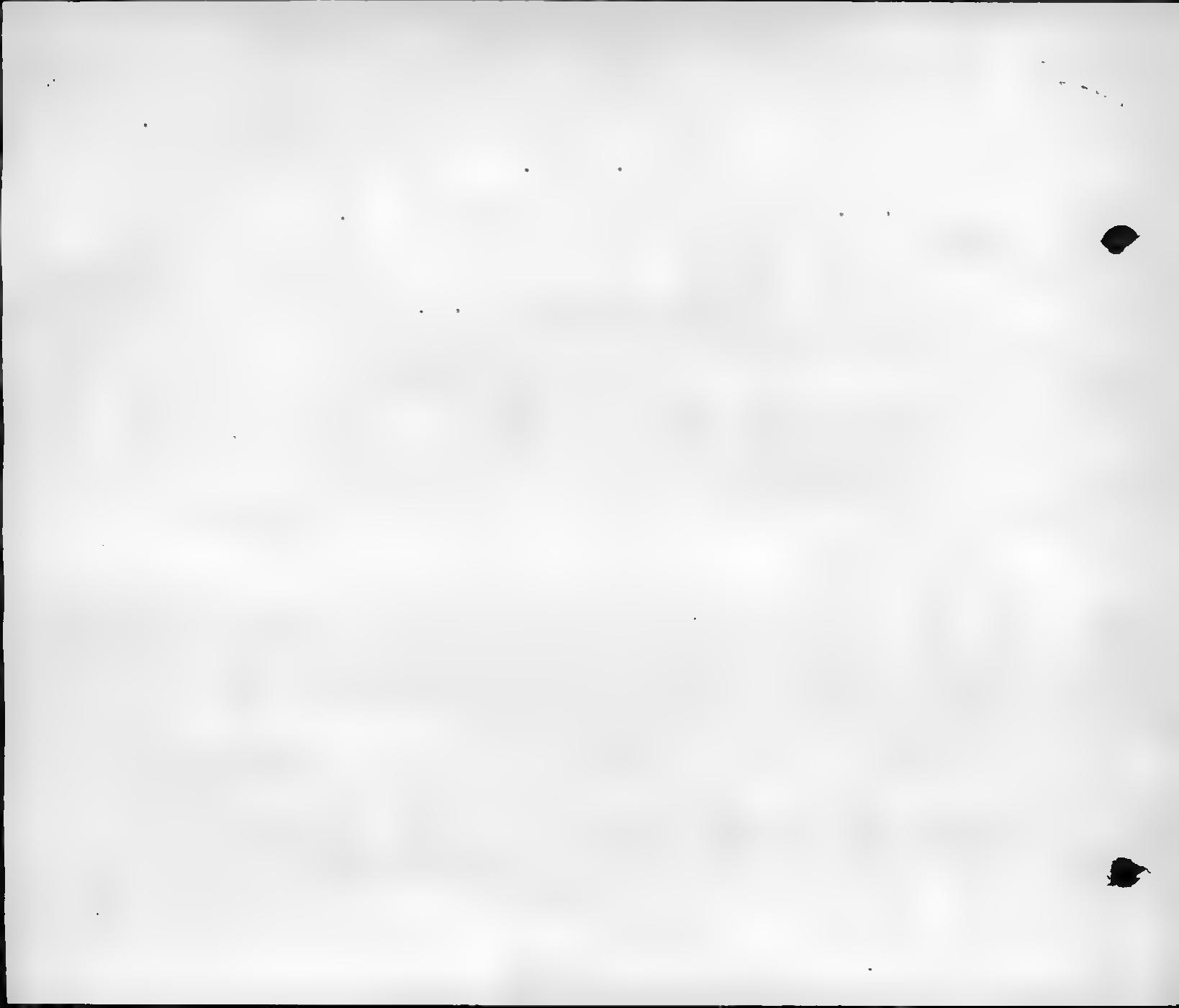
VS ALISME
SM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
7027 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07004

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Montg.		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		c. LENGTH OF STAY IN 16 1 hr. 20 min.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville		d. STREET ADDRESS Seven Locks Rd. RD# 2		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Montg. Co. General						e. IS RES'D ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Mary A		First	Middle	Last	4. DATE OF DEATH June 8 1958	Month	Day	Year 19
5. SEX female		6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH Apr. 14, 1894	9. AGE (In years last birthday) 64 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Edward Schwartzbeck				14. MOTHER'S MAIDEN NAME Jane Kelly				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO None		17. INFORMANT Hospital Record		Address		
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Acute Congestive Cardiac Disease				INTERVAL BETWEEN ONSET AND DEATH 6 hrs		
x 60 X Conditions, if any, which gave rise to immediate cause (a), noting the underlying cause first. (b)		DUE TO Diabetis Mellitus				?		
(c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 20.)						
20c. TIME OF INJURY Hour a. m. p. m.		Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE	<i>Frank J. Broschart</i>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	DATE SIGNED June 8, 1958		
22a. BURIAL/CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/11/58		22c. NAME OF CEMETERY OR CREMATORIUM St. Marys Cemetery		22d. LOCATION (City, town, or county) Rockville, Maryland (State)		
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey Bethesda, Maryland								
24a. REC'D BY REGISTRAR DATE JUN 10 '58						24b. REGISTRAR'S SIGNATURE <i>W.H. Deasey</i>		



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7028

CERTIFICATE OF DEATH

(07005)

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Iowa</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		c. LENGTH OF STAY IN TB 2 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Suburbans</i>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Jenkintown</i>	
3. NAME OF DECEASED (Type or print) <i>Mildred Leone Johnson</i>		d. STREET ADDRESS <i>60 Locust St.</i>	
3. NAME OF DECEASED (Type or print) <i>Mildred Leone Johnson</i>		First <i>Mildred</i>	Middle <i>Leone</i>
3. NAME OF DECEASED (Type or print) <i>Mildred Leone Johnson</i>		Last <i>Johnson</i>	4. DATE OF DEATH <i>June 27 1958</i>
5. SEX <i>Fem</i>		6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <i>6/20/97</i>		9. AGE (In years last birthday) <i>66 yrs.</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Own home</i>	
10c. BIRTHPLACE (State or foreign country) <i>Pennsylvania</i>		11. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>George Carley</i>		14. MOTHER'S MAIDEN NAME <i>Rebecca Crable</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown, if yes give war or date of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>1</i>	
17. INFORMANT <i>Mary D. L. Lockwood</i>		Address <i>505 Fletcher Rockville</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial infarction, post-wall left ventricle</i>		INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i>	
DUE TO (b) <i>Coronary sclerosis, severe</i> DUE TO (c) <i>Atherosclerosis, widespread, severe</i>		years years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Cerebral Thrombosis & Hemiplegia</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>At home</i>		20f. (City or town) <i>(County)</i> <i>(State)</i>	
21. I certify that I attended the deceased from <i>6/25 1958</i> to <i>6/22 1958</i> , that I last saw the deceased alive on <i>6/27 1958</i> , and that death occurred on <i>6/27 1958</i> M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <i>808 University Ave</i>	
ACTUAL SIGNATURE <i>Mildred Johnson</i>		DATE SIGNED <i>6/27/58</i>	
PHYSICIAN'S NAME (Type) <i>H.C. Madanzini</i>		M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) TRANS. & BURIAL 7/2/58		22b. DATE THEREOF <i>7/2/58</i>	
22c. NAME OF CEMETERY OR CREMATORIUM <i>HILLSIDE CEMETERY</i>		22d. LOCATION (City, town, or county) <i>MINNEAPOLIS, MINNESOTA</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Werner E. Humphrey</i>		ADDRESS <i>SILVER SPRING, MD.</i>	
24a. REC'D BY REGISTRAR DATE JUN 30 '58		24b. REGISTRAR'S SIGNATURE <i>W. E. Humphrey</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7029

CERTIFICATE OF DEATH

Reg. Dist. No.

215

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Missouri		b. COUNTY				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN lb 115 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Miller						
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.		d. STREET ADDRESS Rural Route #1		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						
3. NAME OF DECEASED (Type or print)	First Artie	Middle Watson	Last JONES	4. DATE OF DEATH Month June	Day 19	Year 19 58				
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1 May 1926	9. AGE (In years last birthday) 32 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS Days 0	Hours 0	Min. 0		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mariner		10b. KIND OF BUSINESS OR INDUSTRY U.S. Navy Retired		11. BIRTHPLACE (State or foreign country) Missouri		12. CITIZEN OF WHAT COUNTRY U.S.				
13. FATHER'S NAME Watson JONES			14. MOTHER'S MAIDEN NAME Bertha Jewel CATLETT							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Tel. no. or unknown) Yes 1945 to 1-1-54		16. SOCIAL SECURITY NO Unknown		17. INFORMANT Official Navy Records		Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Anaplastic Carcinoma with Metastasis DUE TO 1947.2 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) None										
INTERVAL BETWEEN ONSET AND DEATH 8 Months.										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) None								
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) None		20f. (City or town) None		(County) None	(State) None	
21. I certify that I attended the deceased from 24 February, 1958 , to 19 June, 1958 , that I last saw the deceased alive on 19 June, 1958 , and that death occurred at 9:45 P.M. , from the causes and on the date stated above									ADDRESS (Street, city or town, state) None	DATE SIGNED 6-20-58
ACTUAL SIGNATURE <i>Edwin M. Henness</i> M.D. U.S. Naval Hospital, Bethesda, Md. 6-20-58										
PHYSICIAN'S NAME (Type) Edwin M. Henness, LT, MC, USN		U.S. Naval Hospital, Bethesda, Md.								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-25-58		22c. NAME OF CEMETERY OR CREMATORIUM Pleasant Grove Cemetery		22d. LOCATION (City, town, or county) Miller, Missouri			(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>R.A. Pumphrey</i>		ADDRESS 7557 Wisconsin Ave., Bethesda, Md.		24a. REC'D BY REGISTRAR JUN 24 '58		24b. REGISTRAR'S SIGNATURE <i>Allie Nequin</i>				



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07007

6948

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <i>Wash. D.C.</i>		b. COUNTY <i>Rural</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Pk.</i>		c. LENGTH OF STAY IN 1b <i>60 days</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Washington D.C.</i>		d. STREET ADDRESS <i>1305 Hampton St. N.W.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Wash. San. & Hosp.</i>				e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <i>Elizabeth</i>	Middle <i>Fraser</i>	Last <i>Jones</i>	4. DATE OF DEATH	Month <i>6</i>	Day <i>13</i>	Year <i>1958</i>
5. SEX <i>Female</i>	6. COLOR OR RACE <i>Cauc.</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>2-3-87</i>	9. AGE (In years lost birthday) <i>71 yrs.</i>	IF UNDER 1 YEAR Months <i>0</i>	IF UNDER 24 HRS Days <i>0</i>	Hours <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Minnesota</i>		12. CITIZEN OF WHAT COUNTRY? <i>Amer.</i>	
13. FATHER'S NAME <i>John Cameron</i>		14. MOTHER'S MAIDEN NAME <i>Agnes Bell</i>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown) <i>No</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Patient's Chart (Hospital Record)</i>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>199.7</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Generalized Abdominal Carcinoma</i> 1 yr c ascites							
INTERVAL BETWEEN ONSET AND DEATH							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>7600 Carroll Ave.</i>		20f. (City or town) (County) (State) <i>Baltimore, Md.</i>	
21. I certify that I attended the deceased from <i>Dec. 1957</i> to <i>6-13-1958</i> that I last saw the deceased alive on <i>6-13-1958</i> , and that death occurred at <i>12:20 PM</i> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Paul V. Stava M.D.</i>				ADDRESS (Street, city or town, state) <i>Takoma Park, Md.</i>			
DATE SIGNED <i>6-13-58</i>							
22a. BURIAL/CREMATION REMOVAL (Specify) <i>Burial June 17, 1958</i>		22b. DATE THEREOF <i>June 17, 1958</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>Ft. Lincoln</i>		22d. LOCATION (City, town, or county) <i>Baltimore, Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Deal Funeral Home 4812 Georgia Ave. Mt.</i>		ADDRESS		24a. REC'D BY REGISTRAR DATE <i>JUN 13 '58</i>		24b. REGISTRAR'S SIGNATURE <i>John Smith</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

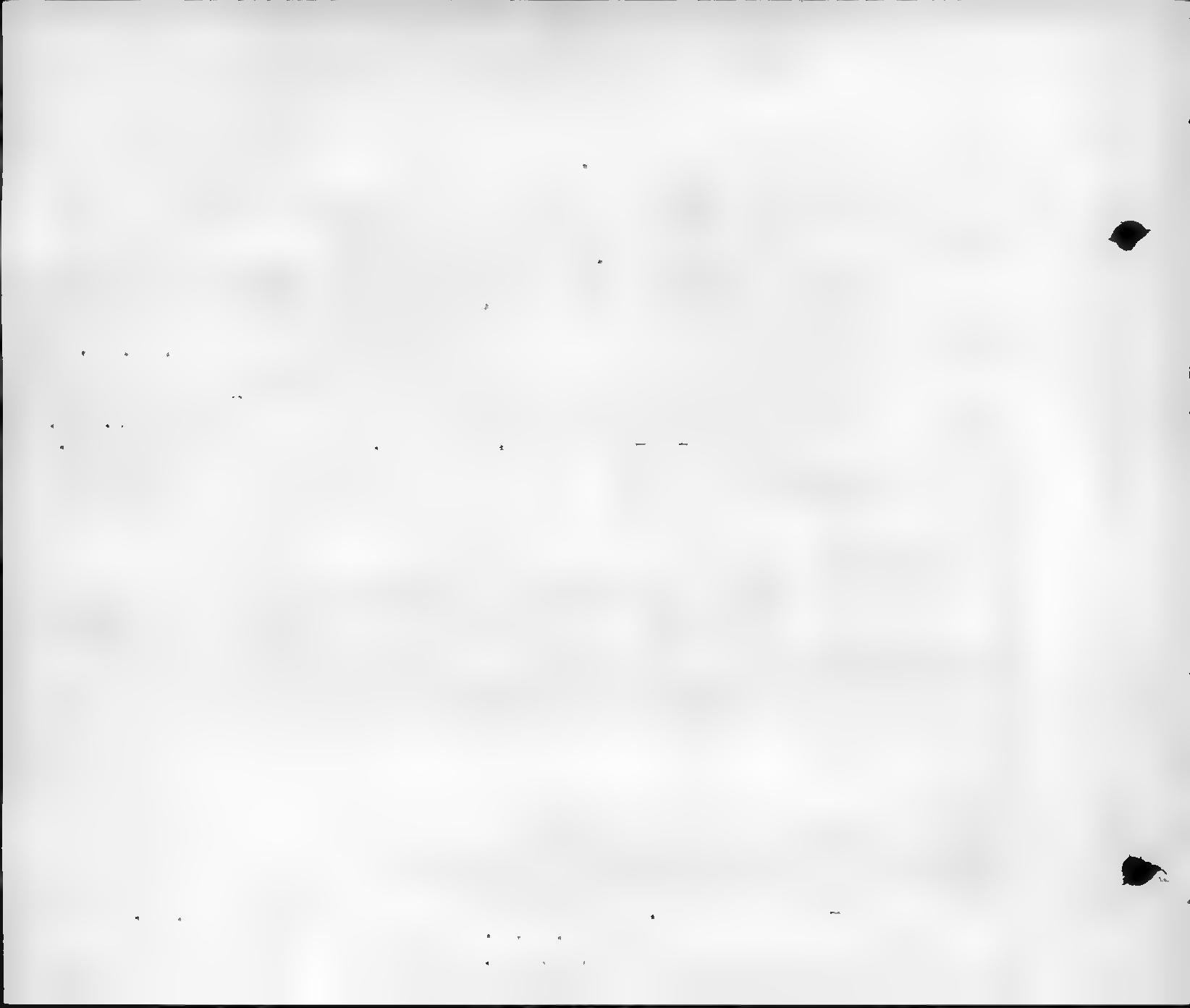
07008

7030

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. LENGTH OF STAY IN 1b 3 yrs.		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 22 MANCHESTER PLACE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)	First JAMES	Middle J.	Last KELLY	
4. DATE OF DEATH	Month 6	Day 12	Year 1958	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Mar. 24, 1885	
9. AGE (In years last birthday) 73 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0	12. IF UNDER 24 HRS Hours 0	
13. FATHER'S NAME HIGH KELLY	14. MOTHER'S MAIDEN NAME WINIFRED -			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no	16. SOCIAL SECURITY NO. 578-24-8972	17. INFORMANT Mrs. Doris M. Kelly	Address Sil. Sp. Rd. 22 Manchester Pl	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic pulmonary emphysema DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)				
INTERVAL BETWEEN ONSET AND DEATH 5 yrs				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. p.m. p. m.	Month 19	Day 12	Year June 12, 1958	
20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 9301 Colersville Rd., Silver Spring, Md.	20f. (City or town) Washington, D. C.	(County) D.C.	(State) D.C.
21. I certify that I attended the deceased from April 12, 1958 , to June 12, 1958 , that I last saw the deceased alive on June 11, 1958 , and that death occurred at 12:45 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Bennet A. Porter, Jr., M.D. DATE SIGNED June 12, 1958				
ACTUAL SIGNATURE Bennet A. Porter, Jr., M.D.	PHYSICIAN'S NAME (Type) Bennet A. Porter, Jr., M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 6-14-58	22c. NAME OF CEMETERY OR CREMATORIUM Mt. Olivet Cemetery	22d. LOCATION (City, town, or county) Washington, D. C.	(State) D.C.
23. FUNERAL DIRECTOR'S SIGNATURE Francis J. Collins	ADDRESS Francis J. Collins 3821 14th St., N.W.	24a. REC'D BY REGISTRAR DATE JUN 13 '58	24b. REGISTRAR'S SIGNATURE Alfred E. L.	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07009

6949

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>			2. USUAL RESIDENCE (Where deceased lived) b. STATE <u>Washington, D.C.</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park, Md.</u>			c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium and Hospital</u>		
e. STREET ADDRESS <u>314 Buchanan St. N.W.</u>			d. STREET ADDRESS <u>47 x - 3</u>		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First <u>Lula</u>	Middle <u>Alberta</u>	Last <u>Kennedy</u>	4. DATE OF DEATH <u>June 1 1958</u>
S SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 3, 1883</u>	9. AGE (in years last birthday) yrs <u>74</u>	IF UNDFT 1 YEAR Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	
13. FATHER'S NAME <u>Jacob Marlowe</u>			14. MOTHER'S MAIDEN NAME <u>Mary Etta Marlow</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO		17. INFORMANT <u>Husband</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>443X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>ArterioSclerotic CVDisease & Hypertension</u>					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>none</u>			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>M.D. 6727-16th St. N.W.</u>	
21. I certify that I attended the deceased from <u>June 2, 1958</u> to <u>June 4, 1958</u> , that I last saw the deceased alive on <u>6-11-58</u> , and that death occurred at <u>59</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>1271 16th St. N.W.</u> DATE SIGNED <u>6-11-58</u>					
ACTUAL SIGNATURE <u>Paul Eanet</u>		PHYSICIAN'S NAME (Type) <u>PAUL EANET, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>6/14/58</u>		22c. NAME OF CEMETERY OR CREMATORIAL <u>Ft. Lincoln Cemetery</u>	
22d. LOCATION (City, town, or county) <u>Prince George, Md.</u>		(State) <u>MD</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>The 3rd has to</u>		ADDRESS <u>2901-4th St. N.W.</u>		24a. REC'D BY REGISTRAR DATE JUN 13 '58	
				24b. REGISTRAR'S SIGNATURE <u>B. W. Schuch</u>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07010

7031

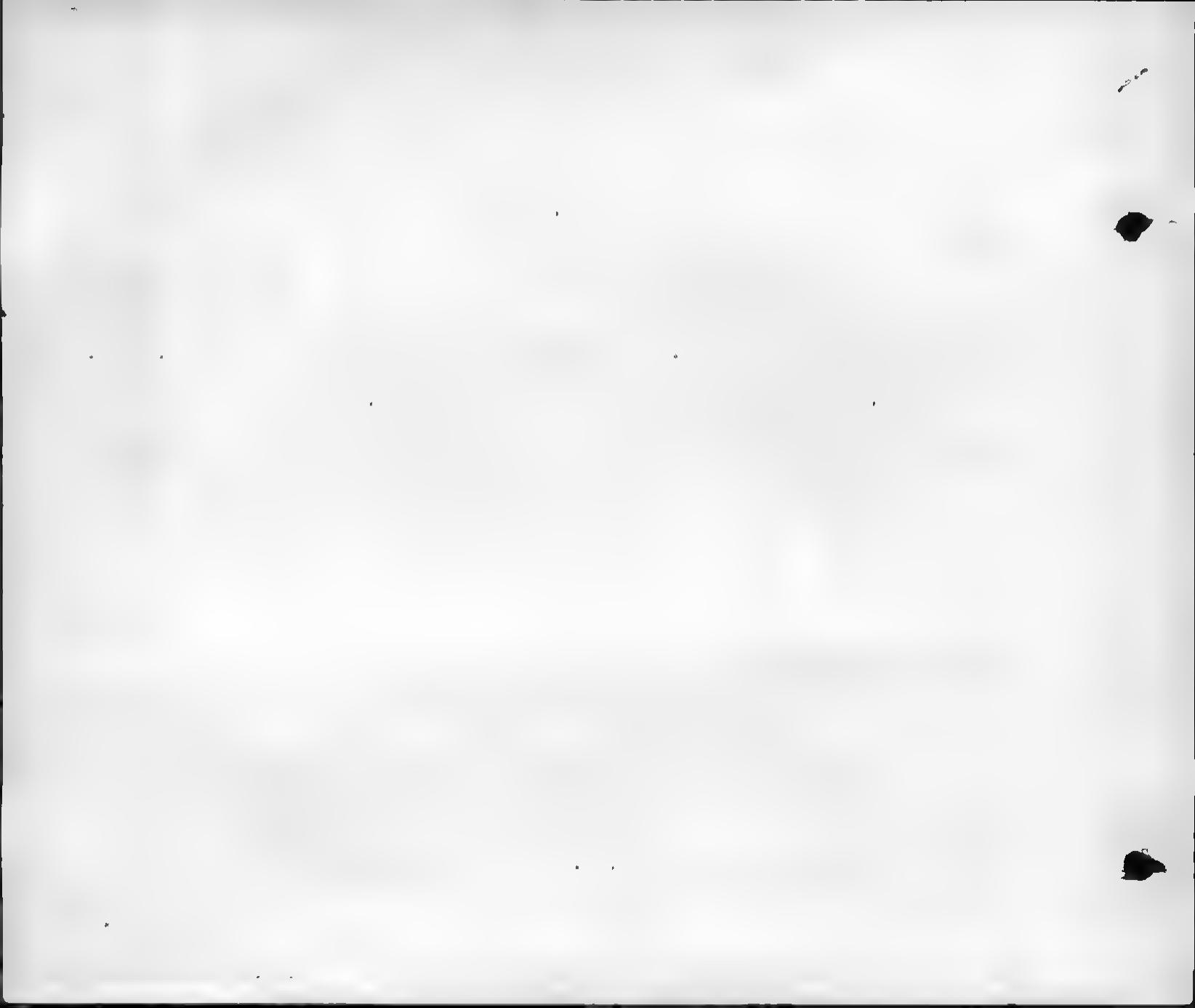
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE Virginia b. COUNTY Arlington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda	c. LENGTH OF STAY IN 1b 1 day	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arlington	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		d. STREET ADDRESS 2239 North Quincy Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First John	Middle Homer	Last Kilby
4. DATE OF DEATH June 24, 1958	Month June	Day 24	Year 1958
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 2, 1901
9. AGE (In years lost birthday) 56 yrs	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Division Director		10b. KIND OF BUSINESS OR INDUSTRY Dept. of Commerce	11. BIRTHPLACE (State or foreign country) New York
12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME William H. Kilby		14. MOTHER'S MAIDEN NAME Anna B. VanDeCar	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO 134-07-7419	17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Medullary glioma</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) <i>Metastatic brain disease</i> DUE TO (c) <i>Anaplastic carcinoma of bladder</i>		INTERVAL BETWEEN ONSET AND DEATH 3 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from June 23, 1958, to June 24, 1958, that I last saw the deceased alive on June 24, 1958, and that death occurred at 1:10 AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center National Institutes of Health Bethesda 14, Maryland			
ACTUAL SIGNATURE <i>Lawrence Schlachter</i>		DATE SIGNED 6/24/58	
PHYSICIAN'S NAME (Type) Lawrence Schlachter, M. D.			
22a. BURIAL, CREMATION REMOVAL (Specify) Burial		22b. DATE THEREOF 6/26/58	22c. NAME OF CEMETERY OR CREMATORIAL Calvary Memorial
22d. LOCATION (City, town, or county) Fairfax County, Va.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Joseph Lavelle, Jr., 1756 Pa Ave., N.W., D.C.</i>		24a. REC'D BY REGISTRAR DATE JUN 27 '58	24b. REGISTRAR'S SIGNATURE <i>John E. Cook</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

07011

7032

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY

Montgomery

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Bethesda

c. LENGTH OF STAY IN 1b

123 days

d. NAME OF HOSPITAL (If not in hospital, give street address)
OR INSTITUTION

The Clinical Center, Bethesda 14, Md.

2. USUAL RESIDENCE (Where deceased lived if institution; Residence before admission)

a. STATE

District of Columbia

b. COUNTY

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Washington 15

47X

d. STREET ADDRESS

3229 Aberfoyle Place, N.W.

e. IS RESIDENCE
ON A FARM?
YES NO 3. NAME OF
DECEASED
(Type or print)

First Posey

Middle Thornton

Last Kime

4. DATE
OF
DEATH

Month June

Day 8

Year 1958

5. SEX

6. COLOR OR RACE

7. MARRIED NEVER MARRIED

8. DATE OF BIRTH

9. AGE (In years
last birthday)10. IF UNDER 1 YEAR
Months 10 Days 2 Hours 12 Min.

Male

White

WIDOWED DIVORCED

6 August 1895

62 yrs

10 months 2 days 12 hours 12 min.

10a. USUAL OCCUPATION (Give kind of work done
during most of working life, even if retired)

Lawyer

10b. KIND OF BUSINESS OR INDUSTRY

Legal Profession

11. BIRTHPLACE (State or foreign country)

Indiana

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

John T. Kime

14. MOTHER'S MAIDEN NAME

Effa Posey

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

yes

(With rank, name or date of service)

16. SOCIAL SECURITY NO.

None

17. INFORMANT

The Medical Record Address

The Clinical Center, Bethesda 14, Maryland

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

Pneumococcal Pneumonia & Pyelonephritis

INTERVAL BETWEEN
ONSET AND DEATH

5 days

Conditions, if any, which
gave rise to immediate
cause (a), stating the under-
lying cause last

DUE TO

DUE TO

(b) Pseudomonas septicemia -

Pseudomonas septicemia -

(c) Aspergillus Pancreatitis

" "

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

Aspergillus Pancreatitis

19. WAS AUTOPSY
PERFORMED?YES NO

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH
(If either, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour a. m. 19 p. m.20d. INJURY OCCURRED
While at work Not while at work 20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I attended the deceased from February 3, 1958, to June 8, 1958, that I last saw the deceased alive on June 8, 1958, and that death occurred at 8:44 AM, from the causes and on the date stated above

ADDRESS (Street, city or town, state)

DATE SIGNED

ACTUAL
SIGNATURE

Habib Bacchus M.D.

The Clinical Center

6-8-58

PHYSICIAN'S
NAME (Type)

Habib Bacchus, M. D.

National Institutes of Health
Bethesda 14, Maryland22a. BURIAL, CREMATION,
REMOVAL (Specify)

Bur-Transit c/10/58

22b. DATE THEREOF

Walnut Hills Cemetery

22c. NAME OF CEMETERY OR CREMATORIUM

22d. LOCATION (City, town, or county)

(State)

Petersburg, Indiana

23. FUNERAL DIRECTOR'S SIGNATURE

Robert A. Pumphrey

ADDRESS

Bethesda, Maryland

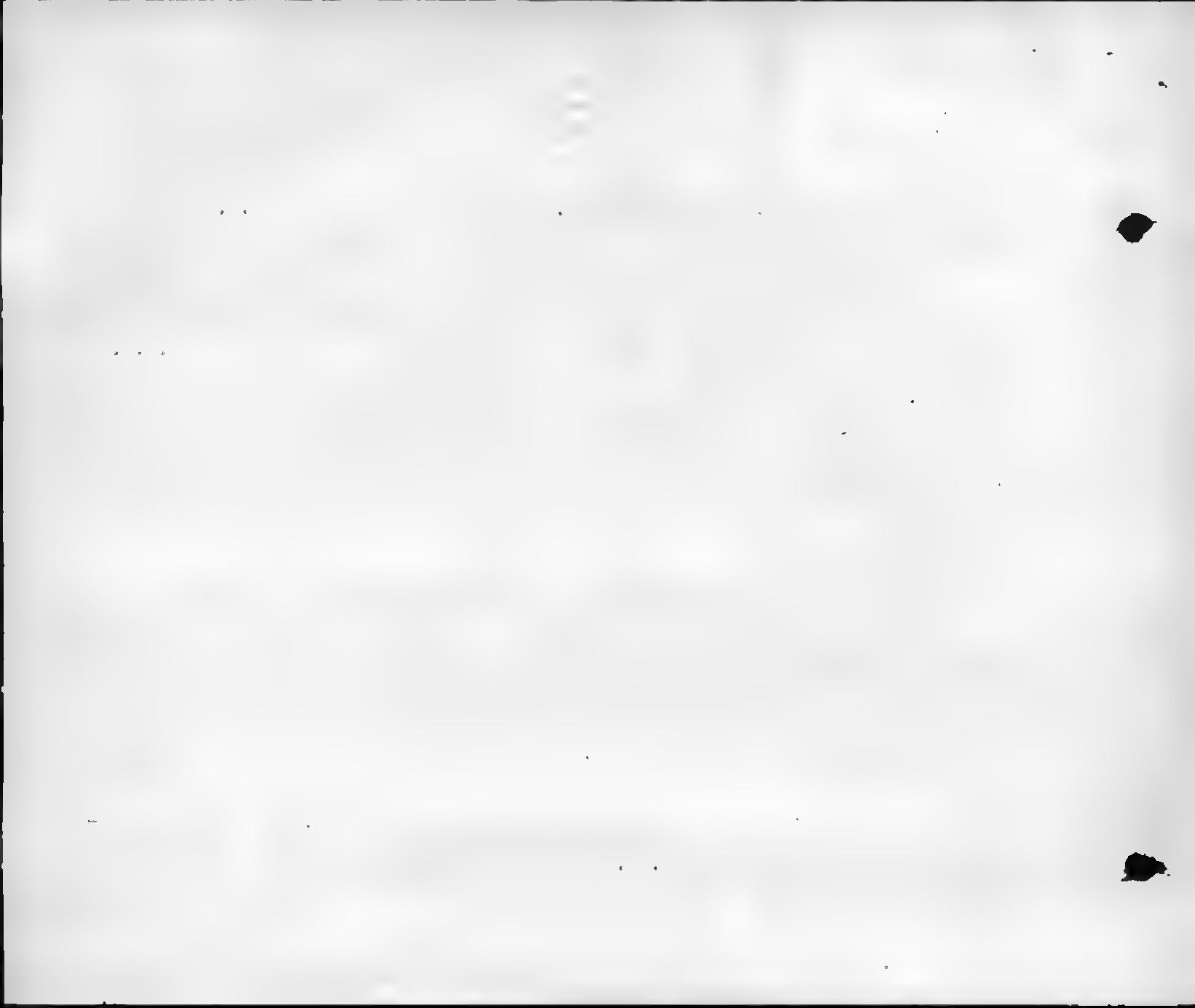
24a. REC'D BY REGISTRAR

DATE

24b. REGISTRAR'S SIGNATURE

JUN 10 1958

Albert Smith



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
7033 CERTIFICATE OF DEATH

07012

Reg. Dist. No. .

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Indiana	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 19 days		d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkhart	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				e. STREET ADDRESS Route 1	
3. NAME OF DECEASED (Type or print) Benjamin Franklin Kindig		First	Middle	Last	4. DATE OF DEATH June 9, 1958
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH September 2, 1882	9. AGE (In years last birthday) 75 yrs	10. UNDER 1 YEAR IF UNDER 24 HRS Months 9 Days 0 Hours 0 Min 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nurseryman		10b. KIND OF BUSINESS OR INDUSTRY Horticulture		11. BIRTHPLACE (State or foreign country) Indiana	
13. FATHER'S NAME David S. Kindig		14. MOTHER'S MAIDEN NAME Rebecca Shively		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] No		16. SOCIAL SECURITY NO. 309-38-7670 Unavailable		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4.0 DUE TO		CEREBRAL HEMORRHAGE		INTERVAL BETWEEN ONSET AND DEATH 2 DAYS	
Conditions, if any which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO		(c) ACUTE LYMPHOCYTIC LEUKEMIA		4 months.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. May 21, 1958		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 21, 1958 , to June 9, 1958 , that I last saw the deceased alive on June 9, 1958 , and that death occurred at 10:15 P.M. from the causes and on the date stated above.				ADDRESS (Street, city or town, state) The Clinical Center	
ACTUAL SIGNATURE Richard K. Shaw		M.D.		DATE SIGNED 6/10/58	
PHYSICIAN'S NAME (Type) Richard K. Shaw, M. D.					
22a. BURIAL, CREMATION OR REMOVAL (Specify) Bur-Transit 6/10/58		22b. DATE THEREOF Rowe Cemetery		22d. LOCATION (City, town, or county) Elkhart, Indiana	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey Bethesda, Maryland		ADDRESS		24a. REC'D BY REGISTRAR DATE JUN 12 '58	
				24b. REGISTRAR'S SIGNATURE Alfred E. ...	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

7034

CERTIFICATE OF DEATH

07013

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Montgomery		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase		d. STREET ADDRESS 3 Primrose Street		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kensington Gardens				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) AGNES		First L.	Middle KLINE	Last	4. DATE OF DEATH Month June 26	Month 1958	Day Year	
S. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> Dec. 19, 1874	9. AGE (In years last birthday) 83 yrs	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0	Hours 0	Min 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Ohio		12. CITIZEN OF WHAT COUNTRY U. S.		
13. FATHER'S NAME Calvin H. Lyon		14. MOTHER'S MAIDEN NAME Mary Chelaweth						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO None		17. INFORMANT Robert Kline, Jr.		Address Same as Item 12		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____								
INTERVAL BETWEEN ONSET AND DEATH 2 mo.								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) senility								
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) fall						
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	Day	20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 1 P. M.	20f. (City or town) Baltimore	(County) Baltimore	(State) Md.	
21. I certify that I attended the deceased from 4/25 , 19 58 , to 6/26 , 19 58 , that I last saw the deceased alive on 6/26 , 19 58 , and that death occurred at 1 P. M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 5 W. Nealon Jr. M.D. 1246 E. Lenox St., Chevy Chase, Md. DATE SIGNED 6/26/58								
ACTUAL SIGNATURE Stephen W. Nealon, Jr.								
PHYSICIAN'S NAME (Type) Stephen W. Nealon, Jr. 104 E. Lenox St., Chevy Chase, Md.								
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 6-27-58		22c. NAME OF CEMETERY OR CREMATORIAL Cedar Hill Crematory		22d. LOCATION (City, town, or county) Prince George Co., Md. (State) Md.		
23. FUNERAL DIRECTOR'S SIGNATURE HOLYDAY A. LUMHOMPT		ADDRESS Bethesda, Md.		24a. REC'D BY REGISTRAR DATE JUN 30 '58		24b. REGISTRAR'S SIGNATURE Alv. Leach		

XX

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07014

6950

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE <i>Wash. D.C.</i>		b. COUNTY <i>b. County</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Jackson Ward</i>		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>wash. D.C. NW 4 1/2 ✓</i>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Washington Sanitarium & Hospital</i>		d. STREET ADDRESS <i>5316 Nevada Ave.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First <i>Bernard</i>	Middle <i>August</i>	Last <i>Kaber</i>	4. DATE OF DEATH Month <i>6 - 20</i>	Year <i>1958</i>			
5. SEX <i>Male</i>	6. COLOR OR RACE <i>Cauc.</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>11-30-92</i>		9. AGE (in years from last birthday) <i>65 yrs</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS Days <i>0</i>	12. HOURS <i>0</i>	13. MIN <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired - Pentagon Cafeteria</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>T.C.</i>		11. BIRTHPLACE (State or foreign country) <i>Amer.</i>		12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <i>Charles C. Kaber</i>		14. MOTHER'S MAIDEN NAME <i>Mary C. Broeker</i>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes or no or unknown) <i>No</i>		16. SOCIAL SECURITY NO		17. INFORMANT <i>Pt. 27 Chart</i>		Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>420.1</i>		DUE TO <i>Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first</i>		<i>Hypertensive Cardiovascular Disease</i>		INTERVAL BETWEEN ONSET AND DEATH <i>2 yrs.</i>			
b) DUE TO <i>Cerebral Infarcts</i>		c) DUE TO <i>Cerebral Infarcts</i>				<i>2 1/2 months</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>M.D. 7701 Carroll Ave</i>		20f. (City or town) <i>Baltimore</i>		(County) <i>None</i>	
20g. (State) <i>Md.</i>									
21. I certify that I attended the deceased from <i>July</i> , 19 <i>57</i> to <i>June 20, 19<i>58</i></i> , that I last saw the deceased alive on <i>June 20, 19<i>58</i></i> , and that death occurred at <i>3:45 P.M.</i> from the causes and on the date stated above				ADDRESS (Street, city or town, state) <i>7701 Carroll Ave</i>		DATE SIGNED <i>6-20-58</i>			
ACTUAL SIGNATURE <i>James W. White</i>									
PHYSICIAN'S NAME (Type) <i>James W. White</i>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>6-23-58</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>Furness</i>		22d. LOCATION (City, town, or county) <i>Baltimore</i>		(State) <i>Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Levi F. Lewis Jr.</i>		ADDRESS <i>1812 St. Mary's Street</i>		24a. REC'D BY REGISTRAR DATE <i>Jul 7 '58</i>		24b. REGISTRAR'S SIGNATURE <i>Alfred J. Schuck</i>			

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07015

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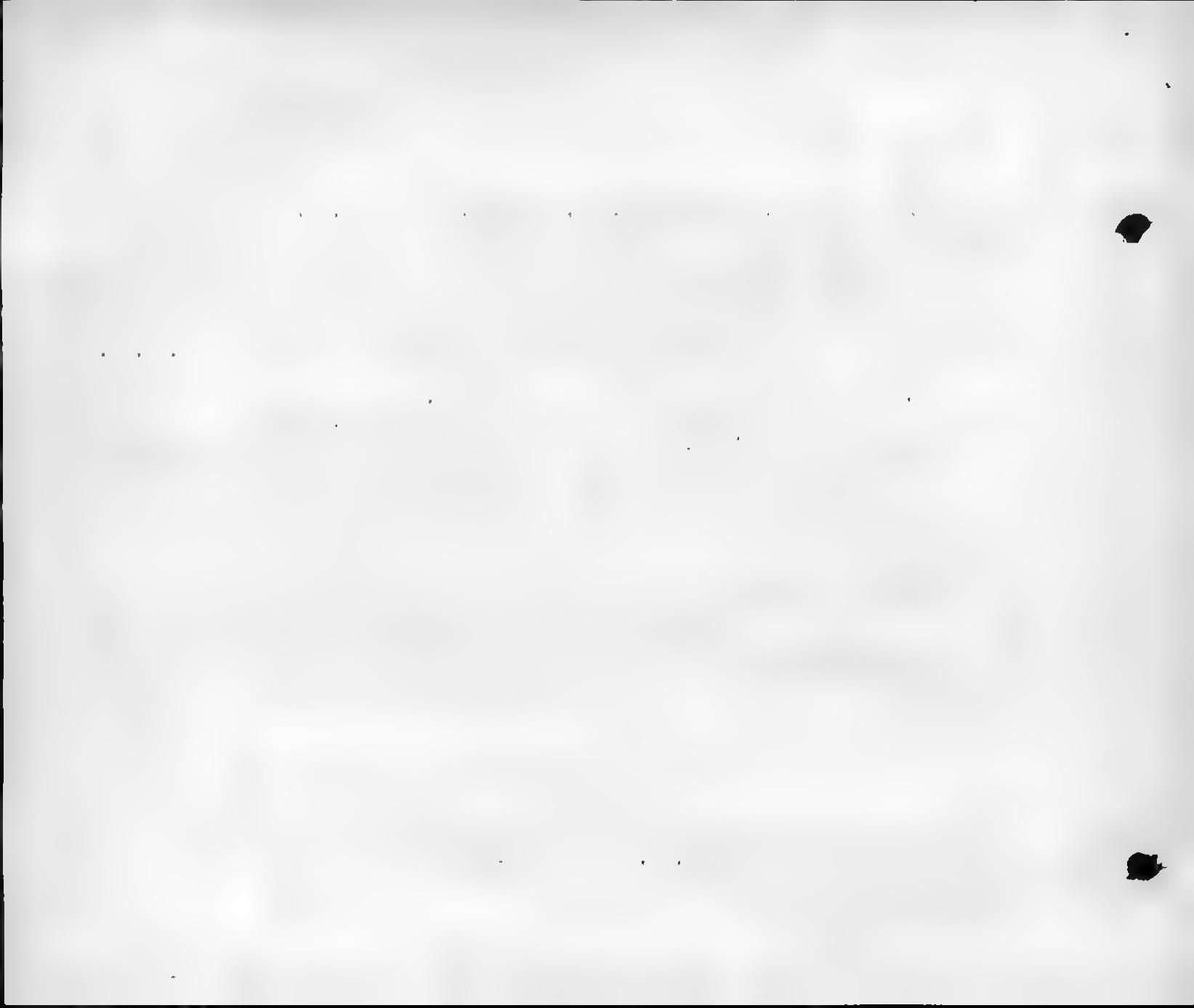
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o COUNTY Montgomery		MARYLAND	2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) o STATE District of Columbia b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 11 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 11, Md.		d. STREET ADDRESS 708 G. Street, S. E.	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Charles	Middle Edward	4. DATE OF DEATH Leapley	Month June	Day 3	Year 1958
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 2, 1916	9. AGE (In years last birthday) 41 yrs	10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter		10b. KIND OF BUSINESS OR INDUSTRY Painting Business	11. BIRTHPLACE (State or foreign country) District of Columbia	12. CITIZEN OF WHAT COUNTRY? U. S. A.		
13. FATHER'S NAME Lewis D. Leapley		14. MOTHER'S MAIDEN NAME Nora V. Grant				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SECURITY # 578-12-6413 INFORMANT The Medical Record Address unascertainable The Clinical Center, Bethesda 11, Maryland				
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) glioblastoma multiforme		INTERVAL BETWEEN ONSET AND DEATH 5 mos				
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)						
18. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Suitland	(County) MD	(State) MD
21. I certify that I attended the deceased from May 23, 1958 , to June 3, 1958 , that I last saw the deceased alive on June 3, 1958 , and that death occurred at 6:45 AM , from the causes and on the date stated above. ACTUAL SIGNATURE Norman H. Bell M.D. ADDRESS (Street, city or town, state) National Institutes of Health Bethesda 11, Maryland		DATE SIGNED 6/3/58				
22a. BURIAL CREMATION, REMOVAL SPECIES BURIAL		22b. DATE THEREOF 6-6-58	22c. NAME OF CEMETERY OR CREMATORIUM Cedar Hill	22d. LOCATION (City, town, or county) Suitland (State) MD		
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Co		ADDRESS 517-11 St SE	24a. REC'D BY REGISTRAR DATE JUN 5 '58	24b. REGISTRAR'S SIGNATURE Alvarez		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07016

CERTIFICATE OF DEATH

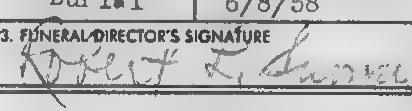
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <i>Maryland</i> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		c. LENGTH OF STAY IN 1b <i>2 hrs</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Suburban</i>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>	
3. NAME OF DECEASED (Type or print) <i>John William Lee</i>		4. DATE OF DEATH <i>June 24, 1958</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <i>3-1-09</i>
WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	9. AGE (In years lost birthday) <i>39 yrs.</i>	
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Undertaking</i>		11. BIRTHPLACE (State or foreign country) <i>D.C.</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>Ernest C Lee</i>	
14. MOTHER'S MAIDEN NAME <i>Florence Roane</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	
16. SOCIAL SECURITY NO.		17. INFORMANT <i>Ernest C Lee Father</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>420.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		Coronary thrombosis INTERVAL BETWEEN ONSET AND DEATH <i>1 day</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Cirrhosis</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Hour a. m. <i>19</i> p. m.	Month, Day, Year <i>19</i>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>1954</i> to <i>24 June, 1958</i> , that I last saw the deceased alive on <i>24 June, 1958</i> , and that death occurred at <i>5:20 P.M.</i> from the causes and on the date stated above		ADDRESS (Street, city or town, state) <i>9026 Coleridge Rd, Silver Spring, Md.</i>	
ACTUAL SIGNATURE <i>William E. Lee</i>		M.D. <i>6/24/58</i>	
PHYSICIAN'S NAME (Type)		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>6-37-58</i>	22b. DATE THEREOF <i>6-37-58</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Rock Creek</i>	22d. LOCATION (City, town, or county) <i>Washington, D.C.</i>
23. FUNERAL DIRECTOR & SIGNATURE <i>Lee Funeral Home - West DC</i>		ADDRESS 24a. REC'D BY REGISTRAR DATE JUN 26 '58	
		24b. REGISTRAR'S SIGNATURE <i>W. Lee</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the register prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										Item 9-10-1962-2-5-1st		07017							
703?					CERTIFICATE OF DEATH					Reg. Dist. No.									
1. PLACE OF DEATH a. COUNTY Montgomery					MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland									
					c. LENGTH OF STAY IN 1b 13 hrs.					b. COUNTY Montgomery									
					d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sandy Spring					c. STREET ADDRESS 									
										e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) Maude Lee					First Middle Last					4. DATE OF DEATH June 5 1958									
5. SEX Female					6. COLOR OR RACE Negro					7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					8. DATE OF BIRTH 2/9/29				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife					10b. KIND OF BUSINESS OR INDUSTRY					11. BIRTHPLACE (State or foreign country) Maryland					9. AGE (In years last birthday) yrs. 29 28				
															IF UNDER 1 YEAR; IF UNDER 24 HRS. Months Days Hours Min.				
															12. CITIZEN OF WHAT COUNTRY? U. S. A.				
13. FATHER'S NAME Hugh Rounds					14. MOTHER'S MAIDEN NAME Elizabeth Newman														
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)					16. SOCIAL SECURITY NO.					17. INFORMANT Richard E. Lee					Address Same				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)															INTERVAL BETWEEN ONSET AND DEATH				
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4-4-4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.					Acute myocardial insufficiency														
(b) DUE TO					Cardiac dilatation and hypertrophy														
(c) DUE TO					Pulmonary hypertension.														
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)															19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)														
20c. TIME OF INJURY Month, Day, Year Hour e. g. 19 p. m.					20d. INJURY OCCURRED While Not while at work <input type="checkbox"/> at work <input type="checkbox"/>					20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)									
21. I certify that I attended the deceased from _____ to _____, that I last saw the deceased alive on _____, and that death occurred at _____ AM, from the causes and on the date stated above.															ADDRESS (Street, city or town, state) Sandy Spring, Maryland				
ACTUAL SIGNATURE 										M.D.					DATE SIGNED JUN 13 '58				
PHYSICIAN'S NAME (Type) C. H. Ligon, M. D.																			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial					22b. DATE THEREOF 6/8/58					22c. NAME OF CEMETERY OR CREMATORIAL Ash Memorial					22d. LOCATION (City, town, or county) Sandy Spring, Md.				
23. FUNERAL DIRECTOR'S SIGNATURE 					ADDRESS Rockville, Md.					24a. REC'D BY REGISTRAR 					24b. REGISTRAR'S SIGNATURE John E. Ligon				
															DATE JUN 13 '58				



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15ME
SM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
7038 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07018

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY

Montgomery

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Silver Spring

c. LENGTH OF STAY IN 1b

20 yrs.

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

716 Chesapeake Avenue

3. NAME OF
DECEASED
(Type or print)

First

Middle

Last
Lefferts

4. DATE
OF
DEATH

Month
June
10

e. IS RESIDENCE
ON A FARM?
YES NO

Year
1958

5. SEX

6. COLOR OR RACE

7. MARRIED

NEVER MARRIED

8. DATE OF BIRTH

Feb. 1, 1898

9. AGE (In years
last birthday)

60

yrs

10. USUAL OCCUPATION (Give kind of work done
during most of working life, even if retired)

(retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

New Jersey

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

XXXXXX William D'Edwine

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)

yes

If yes, give war or dates of service
WW #1

16. SOCIAL SECURITY NO

none

14. MOTHER'S MAIDEN NAME

XXXXXX

Kathryn Cottrell

Address

20 Beach Ave. Eismere,
Delaware

INTERVAL BETWEEN
ONSET AND DEATH

Found dead

in bed

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a)

Coronary occlusion

DUE TO

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

(b)

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY
PERFORMED?
YES NO

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS
PRIMARY or CONTRIBUTING
CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY
Month, Day, Year
Hour
a. m.
p. m.

20d. INJURY OCCURRED
While
at work Not while
at work

20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held on Autopsy , Inspection , Inquiry , and in my opinion death resulted from: Natural causes , Accident , Suicide , Homicide , Undetermined manner

ACTUAL
SIGNATURE

Frank J. Broschart

M.D. CHIEF MEDICAL EXAMINER

DATE SIGNED

EXAMINER'S
NAME (Type)

ASSISTANT MEDICAL EXAMINER

6/10/1958

DEPUTY MEDICAL EXAMINER

22a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL

22b. DATE THEREOF
6/13/58

22c. NAME OF CEMETERY OR CREMATORY

ARLINGTON NAT'L. CEMETERY

22d. LOCATION (City, town, or county)

(State)

ARLINGTON, VIRGINIA

23. FUNERAL DIRECTOR'S SIGNATURE

Warren G. Humphrey

ADDRESS

SILVER SPRING, MD.

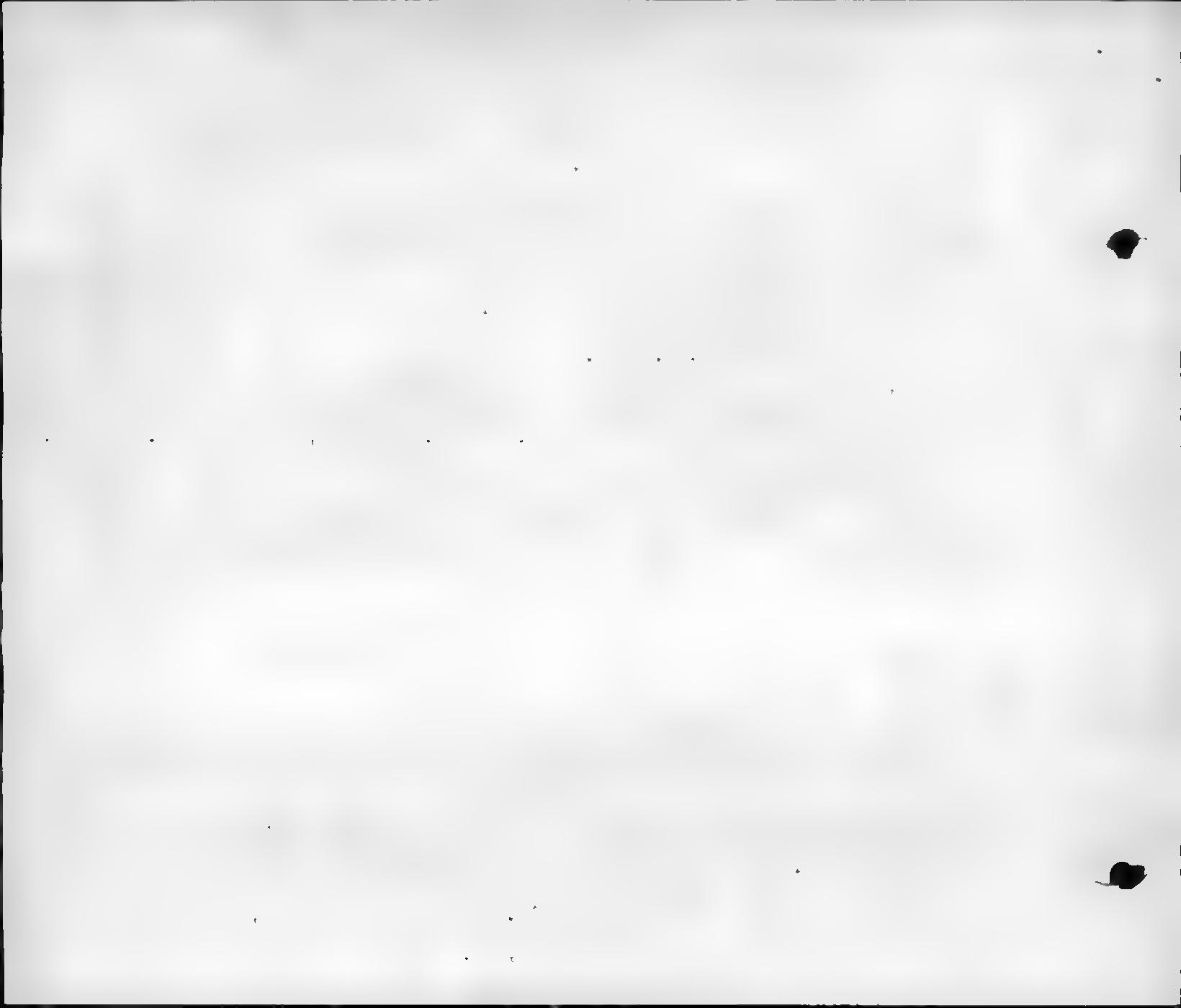
24a. REC'D BY REGISTRAR

JUN 13 1958

24b. REGISTRAR'S SIGNATURE

DATE

A. K. Smith



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
695 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07019

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY Montgomery County				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park				c. LENGTH OF STAY IN 1b D.A.			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington Sanitarium & Hosp.				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring			
3. NAME OF DECEASED (Type or print) Robert				First Robert	Middle Milmore	Last Leishear	4. DATE OF DEATH 6 - 11 - 1958
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 12-19-1906		9. AGE (In years last birthday) 57 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Jeweler				10b. KIND OF BUSINESS OR INDUSTRY Jewelry			
11. BIRTHPLACE (State or foreign country) Washington, D.C.				12. CITIZEN OF WHAT COUNTRY? America			
13. FATHER'S NAME William J. Leishear				14. MOTHER'S MAIDEN NAME Ida Bowler			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 17. INFORMANT 578-18-5573 MRS. Helen Louise Leishear -- same Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Coronary atresia				INTERVAL BETWEEN ONSET AND DEATH sudden			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)							
DUE TO f							
DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .				DATE SIGNED 6-11-58			
ACTUAL SIGNATURE Frank J. Borschart				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) FRANK J. Borschart				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 6/11/58			
22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Oak Hill Cemetery				22d. LOCATION (City, town, or county) (State) Washington, D.C.			
23. FUNERAL DIRECTOR'S SIGNATURE Theodore H. Hines Co. 2901-14th St. N.W.				24a. REC'D BY REGISTRAR DATE JUN 1 1958			
				REGISTRAR'S SIGNATURE C. L. Schaefer			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

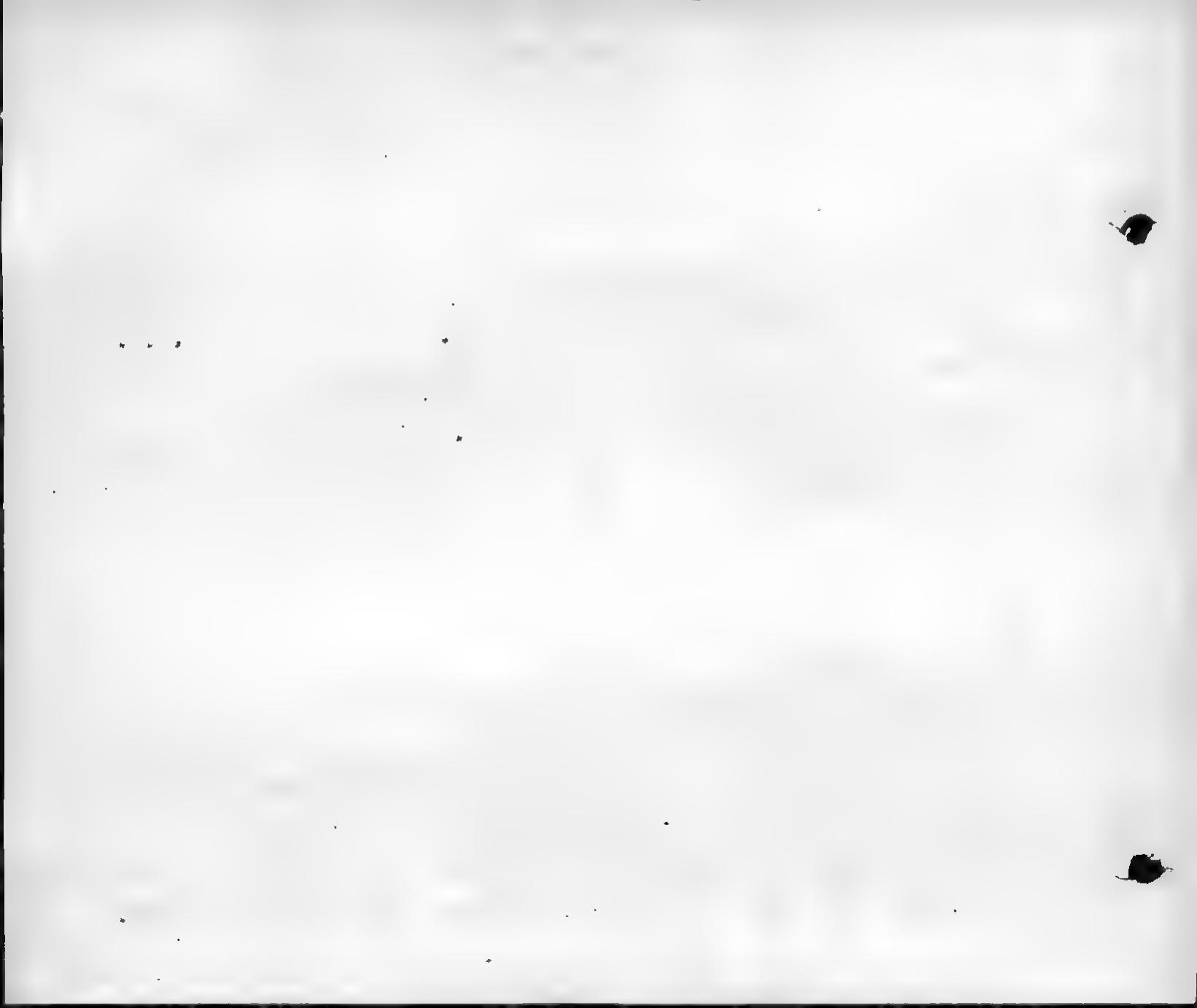
07020

7039

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		b. COUNTY Maryland	
c LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Mont. Co. Gen. Hospital		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Baby Girl	Middle Lindsay	4. DATE OF DEATH June 27 1958
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 27, 1958
9. AGE (In years last birthday) yrs. 3		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min. ~3	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY MD.	
10c. BIRTHPLACE (State or foreign country) MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Roy George Lindsay		14. MOTHER'S MAIDEN NAME Ellen M. Greenwood	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? No		16. SOCIAL SECURITY NO #####	
17. INFORMANT Roy G. Lindsay		Address Same As 2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Fetal distress,</i> DUE TO <i>Prematurity</i>		INTERVAL BETWEEN ONSET AND DEATH 23 min.	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO <i>Prematurity</i> (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not white at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>6/22</u> , 19 <u>58</u> , to <u>6/22</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>6/22</u> , 19 <u>58</u> , and that death occurred at <u>3:45</u> P.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <i>A. D. Bonifant</i>		PHYSICIAN'S NAME (Type) <i>A. D. Bonifant</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 28	
22c. NAME OF CEMETERY OR CREMATORIUM Laytonsville, Md.		22d. LOCATION (City, town, or county) (State) Laytonsville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Roy W. Barber</i>		24a. REC'D BY REGISTRAR DATE JUL 7 '58	
ADDRESS Laytonsville, Md.		24b. REGISTRAR'S SIGNATURE <i>Alfred Cook</i>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07021.

CERTIFICATE OF DEATH

Reg. Dist. No.

7040

1. PLACE OF DEATH
o COUNTY

Montgomery

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Bethesda

c. LENGTH OF STAY IN 1b
RURAL and give nearest town)

13 days

d. NAME OF HOSPITAL (If not in hospital, give street address)
OR INSTITUTION

The Clinical Center, Bethesda 14, Md.

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)

Surinam

b. COUNTY

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

1. Paramaribo

d. STREET ADDRESS

Gonggryp Street

e. IS RESIDENCE
ON A FARM?
YES NO 3. NAME OF
DECEASED
(Type or print)

First

Middle

Last

4. DATE
OF
DEATHMonth
JuneDay
26
Year
1958

Franklin

Leslie

Liqui-Lung

5. SEX

6. COLOR OR RACE

7. MARRIED NEVER MARRIED

8. DATE OF BIRTH

9. AGE (In years
last birthday)10. IF UNDER 1 YEAR
Months Days Hours Min

Male

Yellow

WIDOWED DIVORCED

March 4, 1930

28

yrs

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Student

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Surinam

12. CITIZEN OF WHAT COUNTRY?

Surinam

13. FATHER'S NAME

Fritz Liqui-Lung

14. MOTHER'S MAIDEN NAME

Matilda Tjon-A-Sie

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If no or unknown, (If yes, give war or dates of service))

No

16. SOCIAL SECURITY NO.

None

17. INFORMANT

The Medical Record Address

The Clinical Center, Bethesda 14, Maryland

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

410A

DUE TO

Respiratory Arrest

INTERVAL BETWEEN
ONSET AND DEATH

1 hour

Conditions, if any, which
gave rise to immediate
cause (a), stating the under-
lying cause last.

(b)

DUE TO

Cerebral & abdominal viscerel embol.

30 hours

(c)

Rheumatic Heart Disease w/ L. M. I. Stenosis

15 yrs.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY
PERFORMED?YES NO

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH
(If either, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour o. m.
p. m.20d. INJURY OCCURRED
While Not while
of work at work 20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I attended the deceased from June 13, 1958, to June 26, 1958, that I last saw the deceased alive on June 26, 1958, and that death occurred at 8:05 P.M. from the causes and on the date stated above.

ADDRESS (Street, city or town, state)

DATE SIGNED

ACTUAL
SIGNATURE

John Alfred Lankey

M.D.

The Clinical Center

6/28/58

PHYSICIAN'S
NAME (Type)

John A. Waldhausen, M.D.

National Institutes of Health
Bethesda 14, Maryland22a. BURIAL CREMATION, REMOVAL (Specify)
Burial

22b. DATE THEREOF

(State)

7/1/58

22c. NAME OF CEMETERY OR CREMATORIUM

Gate of Heaven

22d. LOCATION (City, town, or county)

(State)

Silver Spring, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE

Robert A. Pumphrey-Bethesda, Maryland

ADDRESS

24a. REC'D BY REGISTRAR

DATE JUN 30 1958

24b. REGISTRAR'S SIGNATURE

John A. Pumphrey



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07022

Items 2 & 11, File G231, 7/11, Page 10 of 11 CERTIFICATE

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery			MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE District of Columbia					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda			c. LENGTH OF STAY IN b 4 hrs. 20"			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D. C.					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban						d. STREET ADDRESS 2619 Woodley Place,					
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print)		First Baby Girl Luethy		Middle	Lost	4. DATE OF DEATH	Month	Day	Year		
S. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 26 1958	9. AGE (in years last birthday) yrs. 1	IF UNDER 1 YEAR Months	Days	Hours 4	Min 20	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) Montgomery Co., Maryland			12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME			Elizabeth M Luethy			Address Wash., D. C.		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (See box or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.			17. INFORMANT			18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Deceased wife X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1 day
19. WAS AN AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from _____, 19_____, to _____, 19_____, that I last saw the deceased alive on _____, 19_____, and that death occurred at 3:30 PM. Item the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <i>Geo. A. Maxwell</i> PHYSICIAN'S NAME (Type) George A. Maxwell, M. D.											
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation			22b. DATE THEREOF 7-2-58			22c. NAME OF CEMETERY OR CREMATORIAL Suburban Hosp.			22d. LOCATION (City, town, or county) Bethesda, Md. (State)		
23. FUNERAL DIRECTOR'S SIGNATURE			ADDRESS			24a. REGISTRY REGISTRAR DATE JUL 8 1958			24b. REGISTRAR'S SIGNATURE <i>Alt. Redrich</i>		



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6961

CERTIFICATE OF DEATH

Reg. Dist. No.

07023

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Montgomery		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville		c. LENGTH OF STAY IN lb 20 yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville		d. STREET ADDRESS 208 Monroe Street		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 208 Monroe Street				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) WILLIAM G MARTH		First	Middle	Last	4. DATE OF DEATH June 1 1958	Month	Day	Year
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 1883 October 12	9. AGE (In years lost birthday) 74 yrs	IF UNDER 1 YEAR 7 months	IF UNDER 24 HRS. 7 days	Hours	Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Welder-retired		10b. KIND OF BUSINESS OR INDUSTRY Own business		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? US		
13. FATHER'S NAME Leonard Marth		14. MOTHER'S MAIDEN NAME Augusta Groendroff		Address				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Virginia Mundey- same as d2 daughter				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY FIBROSIS DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- (b) Breath of air DUE TO (c) Pulmonary fibrosis INTERVAL BETWEEN ONSET AND DEATH over 11 yrs								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from 1957 to 1958 , that I last saw the deceased alive on July 27 1958 , and that death occurred at 417 M , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 26 N. Summar St. DATE SIGNED July 27 1958								
ACTUAL SIGNATURE Gordon S. Rosenberger		M.D.						
PHYSICIAN'S NAME (Type) Gordon S. Rosenberger								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/4/58		22c. NAME OF CEMETERY OR CREMATORIUM Rockville Cem. Assoc		22d. LOCATION (City, town, or county) Rockville, Maryland		
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		ADDRESS Bethesda, Maryland		24a. REC'D BY REGISTRAR JUN 4 '58		24b. REGISTRAR'S SIGNATURE Alfred E. Schuck		

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

07024

7042

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland		b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Norbeck		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RFD#3 # 2 Silver Spring					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Bradford Rest Home		d. STREET ADDRESS Good Hope Road		e. IS RESIDENCE ON A FARM? * YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF Harry (Type or print)		First	Middle	4. DATE OF DEATH Mathews	Month June	Day 8	Year 1958		
5. SEX male	6. COLOR OR RACE C	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 12 1892	9. AGE (In years (on birthday) 66 yrs.)	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0	Hours 0	Min 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland.		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Wilson Matthews		14. MOTHER'S MAIDEN NAME Margaret Unknown							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Elwood Mathews		Address Fairland Road., Silver Spring, Route #2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coma, Hemiplegia.		INTERVAL BETWEEN ONSET AND DEATH 5 days							
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. Arteriosclerotic Cardiorenal Disease		DUE TO (b) DUE TO (c) Diabetes Mellitus							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Arthritis. Cataract.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) M.D.		20f. (City or town) Rockville		(County) MD	(State) MD
21. I certify that I attended the deceased from Jan 28, 1946 , to June 8, 1958 , that I last saw the deceased alive on June 7, 1958 , and that death occurred at 1:10 AM , from the causes and on the date stated above.									
ACTUAL SIGNATURE Webster Sewell		ADDRESS (Street, city or town, state) Norbeck #1 Silver Spring MD, 20905							DATE SIGNED 6/10/58
PHYSICIAN'S NAME (Type) Webster Sewell									
22a. BURIAL, CREMATION OR REMOVAL (Specify) Burial 6/11/58		22b. DATE THEREOF 6/11/58		22c. NAME OF CEMETERY OR CREMATORIAL Good Hope		22d. LOCATION (City, town, or county) Rockville		(State) MD	
23. FUNERAL DIRECTOR'S SIGNATURE Robert L. Swanson Rockville, MD		ADDRESS Robert L. Swanson Rockville, MD		24a. REC'D BY REGISTRAR DATE JUN 16 '58		24b. REGISTRAR'S SIGNATURE Alv. - eauh			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07025

FOR STATE
HEALTH DEPT.

7043

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY		2. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. LENGTH OF STAY IN lb 8 years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 9000 COLUMBIA BLVD.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING	
f. STREET ADDRESS 9000 COLUMBIA BLVD.		g. S. RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) HAROLD CRITSLOW		First HAROLD	Middle CRITSLOW
4. SEX MALE	5. COLOR OR RACE WHITE	6. MARRIED WIDOWED	7. NEVER MARRIED DIVORCED
8. DATE OF BIRTH 7/12/1900		9. AGE (In years last birthday) 57 yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10b. KIND OF BUSINESS OR INDUSTRY Automobile	
10c. BIRTHPLACE (State or foreign country) OHIO		11. CITIZEN OF WHAT COUNTRY? U.S.A.	
12. FATHER'S NAME Harry McGowan		13. MOTHER'S MAIDEN NAME Suellen Cole	
14. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		15. SOCIAL SECURITY NO. 272-18-6433	
16. INFORMANT Mrs. Gertrude McGowan, wife, same as item 2		17. ADDRESS	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia			
DUE TO 173.1			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)			
DUE TO Carbon monoxide poisoning (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE PRIMARY DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Frank J. Broschart</i>		DATE SIGNED 6/11/58	
EXAMINER'S NAME (Type) FRANK J. BROSCHEART		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION		22b. DATE THEREOF 6/14/58	
22c. NAME OF CEMETERY OR CREMATORIAL Ft. Lincoln Crematory		22d. LOCATION (City, town, or county) Prince Geo. County, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Warren & Thompson</i>		ADDRESS Silver Spring, Md.	
24a. REC'D. BY REGISTRAR JUN 16 1958		24b. REGISTRAR'S SIGNATURE <i>John G. Thompson</i>	
VS A15ME 5M 2/57		DATE	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07026

7044 CERTIFICATE OF DEATH

Reg. Dist. No. 215

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution residence before admission) a. STATE Maryland		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN lb 5 hr. 15 min.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lexington Park		d. STREET ADDRESS 391 Chinlee Drive	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Margaret		First (nm)	Middle MC	Last KISSICK	4. DATE OF DEATH Month June	Day 30	Year 1958
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 6-30-58	9. AGE (In years lost birthday) yrs. 10 Months	10. IF UNDER 1 YEAR Months 10	11. IF UNDER 24 HRS Days 16
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY U.S.	
13. FATHER'S NAME Robert MC KISSICK		14. MOTHER'S MAIDEN NAME Margaret MC CULLOUGH					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes or no or unknown) No		16. SOCIAL SECURITY NO None		17. INFORMANT (Father) Robert MC KISICK (Same As #2)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Principally Atelectasis INTERVAL BETWEEN ONSET AND DEATH DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) Immaturity DUE TO (c)							
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 30 June 1958 to 30 June 1958 , that I last saw the deceased alive on 30 June 1958 , and that death occurred at 8:30 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md. DATE SIGNED 7-2-58							
ACTUAL SIGNATURE <i>J.C. Parke Jr.</i>		NAME (Type) J. C. PARKE JR., LT MC USN U.S. Naval Hospital, Bethesda, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-7-58		22c. NAME OF CEMETERY OR CREMATORIUM Arlington Nat'l Cemetery		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE R.A. Pumphrey, 7557 Wisconsin Ave, Bethesda, Md.		ADDRESS		24a. REC'D BY REGISTRAR DATE JUL 8 '58		24b. REGISTRAR'S SIGNATURE <i>Albert J. Pumphrey</i>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07027

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be given to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		c. LENGTH OF STAY IN 1b <i>Suburban</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Silver Spring</i>		e. STREET ADDRESS <i>2801 Sheraton St.</i>	
3. NAME OF DECEASED (Type or print) <i>Charles</i>		First <i>Charles</i>	Middle <i>HENRY</i>
4. DATE OF DEATH Month <i>6</i>		Lost <i>10-28-18</i>	Day Year <i>28 1958</i>
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <i>10-28-18</i>	
9. AGED (In years last birthday) <i>39 yrs.</i>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Printer</i>	
11. KIND OF BUSINESS OR INDUSTRY <i>M.S. Corp.</i>		12. BIRTHPLACE (State or foreign country) <i>Penn</i>	
13. FATHER'S NAME <i>Charles H. McMullen</i>		14. MOTHER'S MAIDEN NAME <i>Aura Vaswinkle</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>Yes / Army</i>		16. SOCIAL SECURITY NO. <i>WW2 201-01-5747</i>	
17. INFORMANT <i>Mrs. Phyllis E. McMullen, 2801 Sheraton</i>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary occlusion</i> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)	
19. WAS AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.	
20c. TIME OF INJURY Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State) <i>(None)</i>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>Frank J. Buschbeck</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <i>FRANK J. BUSCHBECK</i>		6-28-58	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		22b. DATE THEREOF <i>7/1/58</i>	
22c. NAME OF CEMETERY OR CREMATORIUM <i>ARLINGTON NAT'L. CEMETERY</i>		22d. LOCATION (City, town, or county) (State) <i>ARLINGTON, VIRGINIA</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Warren L. Campbell</i>		ADDRESS <i>SILVER SPRING, MD.</i>	
24a. REC'D BY REGISTRAR DATE <i>JUL 2 '58</i>		24b. REGISTRAR'S SIGNATURE <i>W. L. Campbell</i>	



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 1B. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PK3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07028

Reg. Dist. No.

7046

1. PLACE OF DEATH

IN COUNTY

Montgomery

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Onley

c. LENGTH OF STAY IN 1b

15 min.

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Montgomery County General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)

a. STATE Maryland

b. COUNTY Montgomery

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Rockville

d. STREET ADDRESS

16209 Emory Lane

e. IS RESIDENT ON A FARM?
YES NO

3. NAME OF
DECEASED
(Type or print)

First

Middle

Last

4. DATE
OF
DEATH

Month

Day

Year

5. SEX

6. COLOR OR RACE

7. MARRIED NEVER MARRIED

8. DATE OF BIRTH

Female

White

WIDOWED

DIVORCED

March 29, 1894

9. AGE (In years
last birthday)

64 yrs

10. IF UNDER 1 YEAR
Months Days Hours Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10b. KIND OF BUSINESS OR INDUSTRY

Own home

11. BIRTHPLACE (State or foreign country)

Neb.

12. CITIZEN OF WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

David Taylor

14. MOTHER'S MAIDEN NAME

Sue Nutt

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown)
NO

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

none F. A. Michels (husband) Item 2

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

Acute congestive heart disease

INTERVAL BETWEEN
ONSET AND DEATH
10 min.

416 X

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

(b)

Rheumatic heart disease

?

DUE TO

(c)

Bronchial asthma

years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 19. WAS AUTOPSY
PERFORMED?

YES NO

20a. EXTERNAL CAUSE WAS

PRIMARY or CONTRIBUTING

CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY

Month, Day, Year

Hour

o. m.

p. m.

19

20d. INJURY OCCURRED

White
at work Not white
at work

20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy Inspection , Inquiry , and in my opinion death resulted from: Natural causes Accident , Suicide , Homicide , Undetermined manner

ACTUAL
SIGNATURE: *Frank J. Broschart*

M.D. CHIEF MEDICAL EXAMINER

ASSISTANT MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

DATE SIGNED

6/12/58

22a. BURIAL / CREMATION, 22b. DATE THEREOF

REMOVAL (Specify)
TRANS. & BURIAL 6/16/58

22c. NAME OF CEMETERY OR CREMATORIUM

CROWN HILL CEMETERY

22d. LOCATION (City, town, or county)

Denver, Colorado

(State)

23. FUNERAL DIRECTOR'S SIGNATURE

John J. Humphrey

ADDRESS

SILVER SPRING, MD.

24a. REC'D BY REGISTRAR

DATE 16 '58

24b. REGISTRAR'S SIGNATURE

John J. Humphrey



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

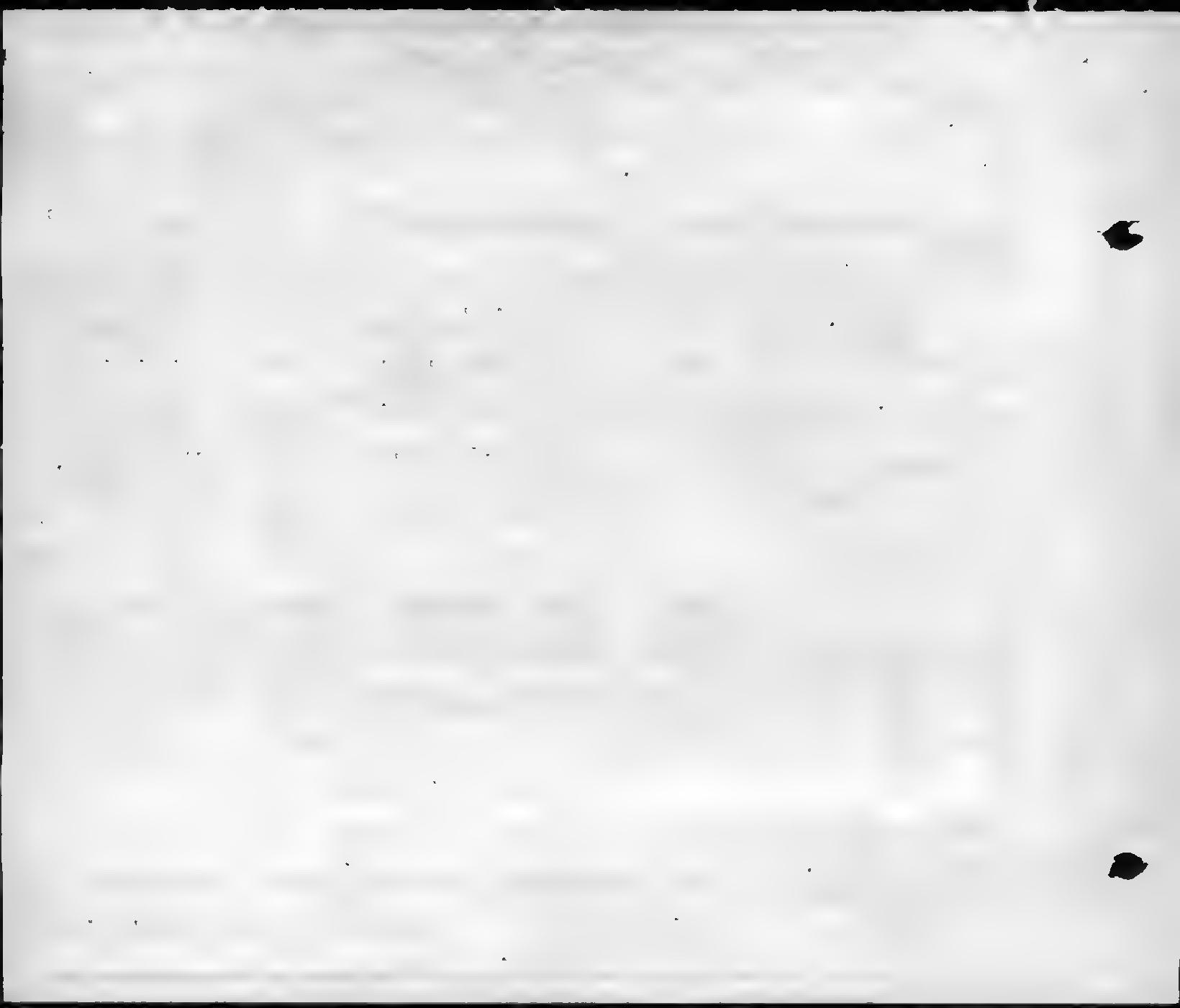
07029

7047

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution; Residence before admission) a. STATE MARYLAND		b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. LENGTH OF STAY IN 1b 2 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		d. STREET ADDRESS 1909 ROOKWOOD ROAD			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1909 ROOKWOOD ROAD				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) ESTELLA LOUISA MILLER		First	Middle	Last	4. DATE OF DEATH June 15 1958	Month	Day	Year	
5. SEX FEMALE		6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JAN. 6, 1870	9. AGE (in years at birthday) 88	10. IF UNDER 1 YEAR IF UNDER 24 HRS Months 0	Days 0	Hours 0	Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (State or foreign country) GORDON, PA.		12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME JAMES M. SEITZINGER		14. MOTHER'S MAIDEN NAME Hannah Caroline Ebert							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT JAMES E. MILLER, 1909 ROOKWOOD RD., SILVER SPRING		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)				Coronary Occlusion		INTERVAL BETWEEN ONSET AND DEATH 41 days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) None						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None							
20c. TIME OF INJURY Hour a.m. p. m. 19		Month, Day, Year March 1958	20d. INJURY OCCURRED While of work <input type="checkbox"/> at work <input type="checkbox"/> Not while at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 1919 Seminary Rd	20f. (City or town) Silver Spring	(County) Prince George County	(State) Md.		
21. I certify that I attended the deceased from March 1958 to June 15, 1958 that I last saw the deceased alive on June 15, 1958 , and that death occurred at 11:55 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 1919 Seminary Rd DATE SIGNED John S. Rogers M.D. June 15, 1958									
22a. BURIAL, CREMATION, OR REMOVAL (Specify) CREMATION		22b. DATE THEREOF 6/18/58		22c. NAME OF CEMETERY OR CREMATORIAL FT. LINCOLN CREMATORY		22d. LOCATION (City, town, or county) (State) Prince George County, Md.			
23. FUNERAL DIRECTOR'S SIGNATURE Warren & Humphrey		ADDRESS Silver Spring, Md.		24a. REC'D BY REGISTRAR DATE JUN 17 1958		24b. REGISTRAR'S SIGNATURE John S. Rogers			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
6952 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07030

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for you.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-trust permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE	
<i>Montgomery Co., Maryland</i>		<i>Virginia</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb	
<i>Takoma Pk. Md</i>		<i>D.C.</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
<i>Wash. San. & Hosp</i>		<i>Haymarket</i>	
f. STREET ADDRESS		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First	Middle
<i>Frank Eugene Moose</i>			
4. DATE OF DEATH		Month	Day
		6	7
5. SEX		6. COLOR OR RACE	7. MARRIED
<i>m</i>		<i>wh</i>	<input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED
8. DATE OF BIRTH		9. AGE (in years last birthday)	
		<i>Dec 23 - 1898 59 yrs.</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
<i>Electrical business</i>		<i>retired</i>	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<i>Penn.</i>		<i>U.S.A.</i>	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
<i>Clarence Hepler</i>		<i>adopted Mrs Daisy Hepler</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]	
		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	
DUE TO		<i>Cerebral hemorrhage & laceration</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first.		DUE TO	
(b) <i>Compound fracture of skull</i>		DUE TO	
(c) <i>Shot gun wound</i>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
		<i>Sudden</i>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
		<i>Shot self with shot gun in bed room of daughter home</i>	
20c. TIME OF INJURY Month, Day, Year Hour : o m 1 - 7 - 1958		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>7215 15th Ave</i>	
		20f. (City or town) (County) (State) <i>Takoma Park, D.C.</i>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>Frank J. Broderick</i>		DATE SIGNED <i>6-7-58</i>	
EXAMINER'S NAME (Type) <i>Frank J. Broderick</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REBURN (Specify) <i>Reburial</i>		22b. DATE THEREOF <i>6-11-58</i>	
22c. NAME OF CEMETERY OR CREMATORIAL <i>Rid. Nat. Cem.</i>		22d. LOCATION (City, town, or county) (State) <i>Fort Myers - Fla.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>J.W. Less Son</i>		ADDRESS <i>Wash. D.C.</i>	
24a. REC'D BY REGISTRAR DATE <i>JUN 1 1958</i>		24b. REGISTRAR'S SIGNATURE <i>John R. Evans</i>	

time

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

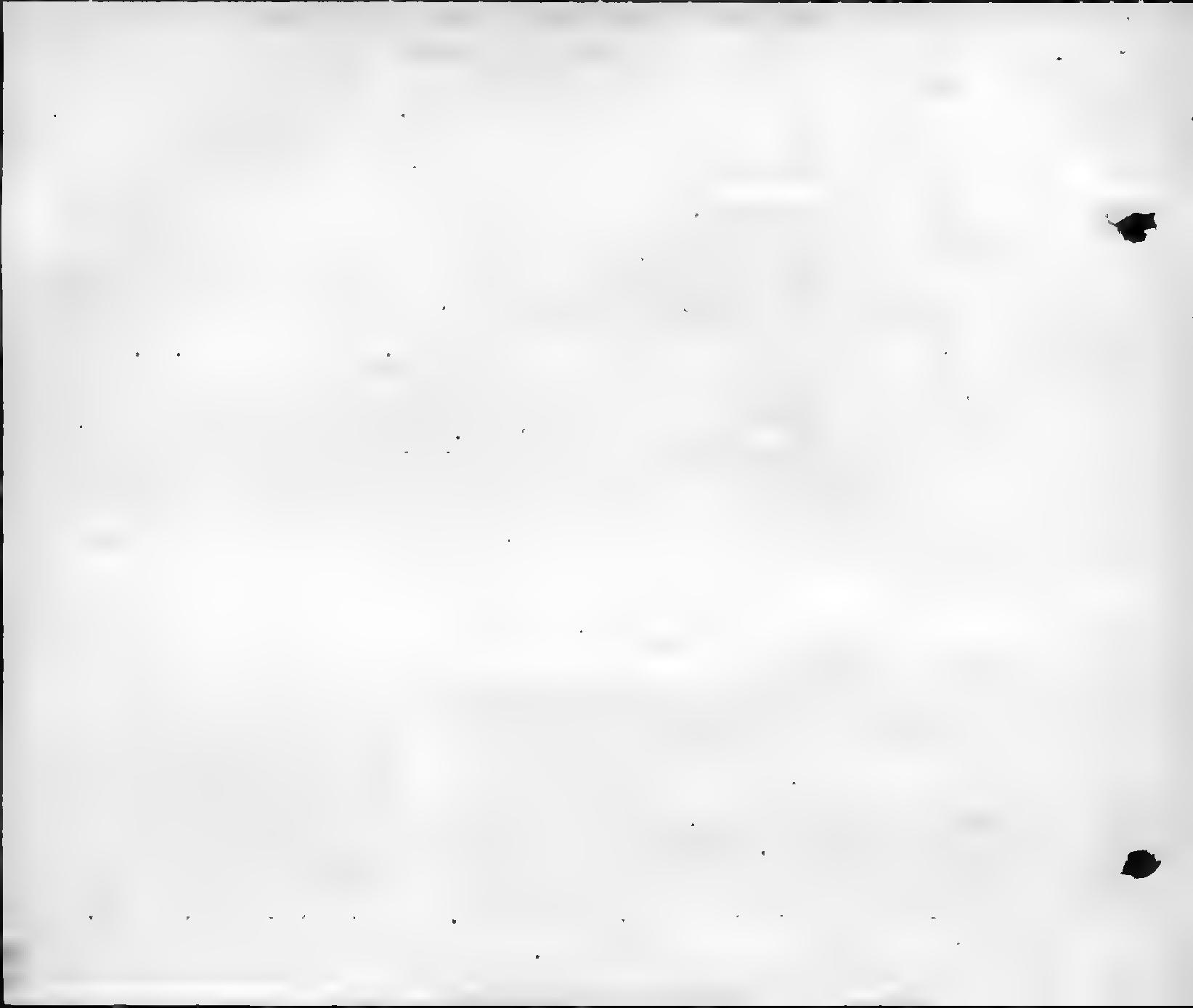
07031

7048

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution give name and address) a. STATE Penna.		Residence before admission b. COUNTY Berks County			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kenwood		c. LENGTH OF STAY IN 1b 7 Months		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gibraltar		d. STREET ADDRESS 7575 S. Ringfield Drive			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5707 S. Ringfield Drive		d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) ELIZABETH M. MOYER		First	Middle	Last	4. DATE OF DEATH June 22 1958	Month	Day	Year	
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/>	8. DATE OF BIRTH May 30, 1875	9. AGE (In years last birthday) 83 yrs	10. IF UNDER 1 YEAR, IF UNDER 24 HRS Months 8	Days 22	Hours 0	Min 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Penna.		12. CITIZEN OF WHAT COUNTRY U. S.			
13. FATHER'S NAME Jacob Murray		14. MOTHER'S MAIDEN NAME Harriett Wickline				Address Same as Item 11			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give rank or date of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT George A. Pleam Son-in-Law		INTERVAL BETWEEN ONSET AND DEATH 4 days			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Uremia 12X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) Chronic Glomerulo Nephritis DUE TO (c) indefinite									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Arterio - venous heart disease						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Washington		(County) Washington	(State) D.C.
21. I certify that I attended the deceased from alive on June 22 1958 , and that death occurred at 8:30 A.M. from the causes and on the date stated above						ADDRESS (Street, city or town, state) Washington Clinic, Washington 15 D.C.		DATE SIGNED 6-22-58	
ACTUAL SIGNATURE Robert G. Taylor		PHYSICIAN'S NAME (Type) ROBERT G. TAYLOR							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial-Transit		22b. DATE THEREOF 6-23-58		22c. NAME OF CEMETERY OR CREMATORIUM St. John's Cemetery		22d. LOCATION (City, town, or county) Berks County, Penna.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Humphrey		ADDRESS Bethesda, Md.		24a. REG'D BY REGISTRAR DATE JUN 25 1958		24b. REGISTRAR'S SIGNATURE Robert A. Humphrey			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7049 CERTIFICATE OF DEATH

07032

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 5601 Wyngate Drive		c. LENGTH OF STAY IN 1b <i>Yes.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda Md		d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS 5601 Wyngate Drive		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) <i>SARAH JEROME MURPHY</i>		Middle Name <i>First</i>		Last Name <i>Murphy</i>		4. DATE OF DEATH <i>JUNE 25 1958</i>	Month <i>JUNE</i>	Day <i>25</i>	Year <i>1958</i>
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5. SEX <i>FEMALE</i>	6. COLOR OR RACE <i>WHITE</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>OCT 15, 1885</i>	9. AGE (In years last birthday) <i>72 yrs</i>	10. IF UNDER 1 YEAR IF UNDER 24 HRS Months <i>0</i>	Days <i>0</i>	Hours <i>0</i>	Min. <i>0</i>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY own home	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13. FATHER'S NAME James W Higgs	14. MOTHER'S MAIDEN NAME Alice Welch	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY NO <i>none</i>	17. INFORMANT Joseph A Murphy	Address Bethesda Maryland.
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18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>CEREBRAL HEMIPLA</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>1 WEEK</i>
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>PARKETTS ALLERGY</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <i>falling down</i>		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>home</i>	20f. (City or town) (County) (State) <i>Bowie, Maryland</i>
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21. I certify that I attended the deceased from <i>SEPT 26, 1958</i> to <i>JUNE 24, 1958</i> , that I last saw the deceased alive on <i>JUNE 24, 1958</i> , and that death occurred at <i>7:45 A.M.</i> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <i>6260-A H. Rd.</i>	DATE SIGNED <i>6/26/58</i>
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ACTUAL SIGNATURE <i>R.C. KIRCHNER M.D.</i>		PHYSICIAN'S NAME (Type) <i>R.C. KIRCHNER M.D.</i>	
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22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>6/27/58</i>	22c. NAME OF CEMETERY OR Crematory <i>Church of Ascension</i>	22d. LOCATION (City, town, or county) (State) <i>Bowie, Maryland</i>
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23. FUNERAL DIRECTOR'S SIGNATURE <i>F Gasch's Sons Hyattsville, Maryland.</i>	ADDRESS	24a. REC'D BY REGISTRAR DATE JUN 30 '58 <i>D. L. Smith</i>	24b. REGISTRAR'S SIGNATURE
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death by the funeral director, may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death - Page 4

may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
G-231 7/10/58.cac. 6953 CERTIFICATE OF DEATH 07033

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		c. LENGTH OF STAY IN 1b <i>1 D.D.A.</i>		d. STATE <i>Maryland</i>		b. COUNTY <i>Montgomery</i>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Washington Sanitarium & Hospital</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <i>Emma Louise Naegler</i>		First <i>Emma</i>	Middle <i>Louise</i>	Last <i>Naegler</i>	4. DATE OF DEATH Month <i>6</i> Day <i>19</i> Year <i>1958</i>	Month	Day	Year		
S. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>FEBRUARY 9, 1884</i>	9. AGE (In years last birthday) <i>74 yrs</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS Days <i>0</i>	12. IF UNDER 24 HRS Hours <i>0</i>	13. IF UNDER 24 HRS Min <i>0</i>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Own home</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>America</i>				
13. FATHER'S NAME <i>John Bailey</i>		14. MOTHER'S MAIDEN NAME <i>Clark</i>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>NONE</i>			17. INFORMANT <i>Son-in-law</i>	Address <i>Homer J. Booth - 7019 Georgia Ave - DC</i>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) <i>Acute Myocardial Infarction</i>		DUE TO <i>Arteriosclerotic Heart Disease</i>		INTERVAL BETWEEN ONSET AND DEATH <i>20 min</i>						
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b)		DUE TO <i>Hyper tension Cardiac decomp. Signs.</i>		5 yrs						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) <i>None</i>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)								
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p. m. _____ <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>None</i>		20f. (City or town) <i>Bethesda</i>	(County) <i>Montgomery</i>	(State) <i>Maryland</i>		
21. I certify that I attended the deceased from <i>May 1958</i> to <i>June 1958</i> that I last saw the deceased alive on <i>June 1958</i> , and that death occurred on <i>June 1958</i> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <i>8641 - Cromwell Dr.</i>								
ACTUAL SIGNATURE <i>Ralph F. Patterson, M.D.</i>		DATE SIGNED <i>8/6/58</i>								
PHYSICIAN'S NAME (Type) <i>Ralph F. Patterson</i>										
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF <i>6/21/58</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>FT. LINCOLN CEMETERY</i>		22d. LOCATION (City, town, or county) <i>PRINCE GEO. COUNTY, MARYLAND</i>				
23. FUNERAL DIRECTOR'S SIGNATURE <i>Clarence S. Humphrey</i>		ADDRESS <i>SILVER SPRING, MD.</i>		24a. REC'D BY REGISTRAR DATE <i>JUN 2 P '58</i>		24b. REGISTRAR'S SIGNATURE <i>C. L. Smith</i>				



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7050

CERTIFICATE OF DEATH

Reg. Dist. No.

07034

1. PLACE OF DEATH a. COUNTY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution, residence before admission)	
Montgomery				a. STATE	Maryland
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN b. RURAL and give nearest town)		b. COUNTY	Montgomery
Bethesda		D.O.B.		Silver Spring	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Suburban Hospital		2312 Seminary Road			
3. NAME OF DECEASED (Type or print)	First	Middle	Last	4. DATE OF DEATH	Month Day Year
				June	14 19 58
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday) 74 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.
female	white		Jan 16, 1886	74 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Housewife.		—		Calmet Mich.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
Peter Moon		unknown		America	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO		Address 2312 Seminary Rd Silver Spring, Md.	
(If yes, give war or dates of service)		none Mrs Helen Woodworth			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)]		INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Thrombosis, Right coronary artery 460.1			
DUE TO		2 hr.			
Conditions if any, which gave rise to immediate cause (a), stating the under- lying cause last.		Coronary sclerosis, severe			
(b)		years			
(c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20c. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20d. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m.		20e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20f. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (County) (State)	
21. I certify that I attended the deceased from Feb. 1957, to 14 June 1958, that I last saw the deceased alive on 14 June 1958, and that death occurred at 1:00 AM, from the causes and on the date stated above		ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE		M.D. 1134 Georgetown St. 14 June 1958			
PHYSICIAN'S NAME (Type)		MERTON L. WHITE			
22a. BURIAL CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIAL Parkview Cemetery	
Burial		June 17, 1958		(City, town or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR	
J. Arthur Shultz		254 Carroll St. N.W. Washington 17, D.C.		DATE JUN 17 1958	
				24b. REGISTRAR'S SIGNATURE	

DO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

DO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
6962 CERTIFICATE OF DEATH

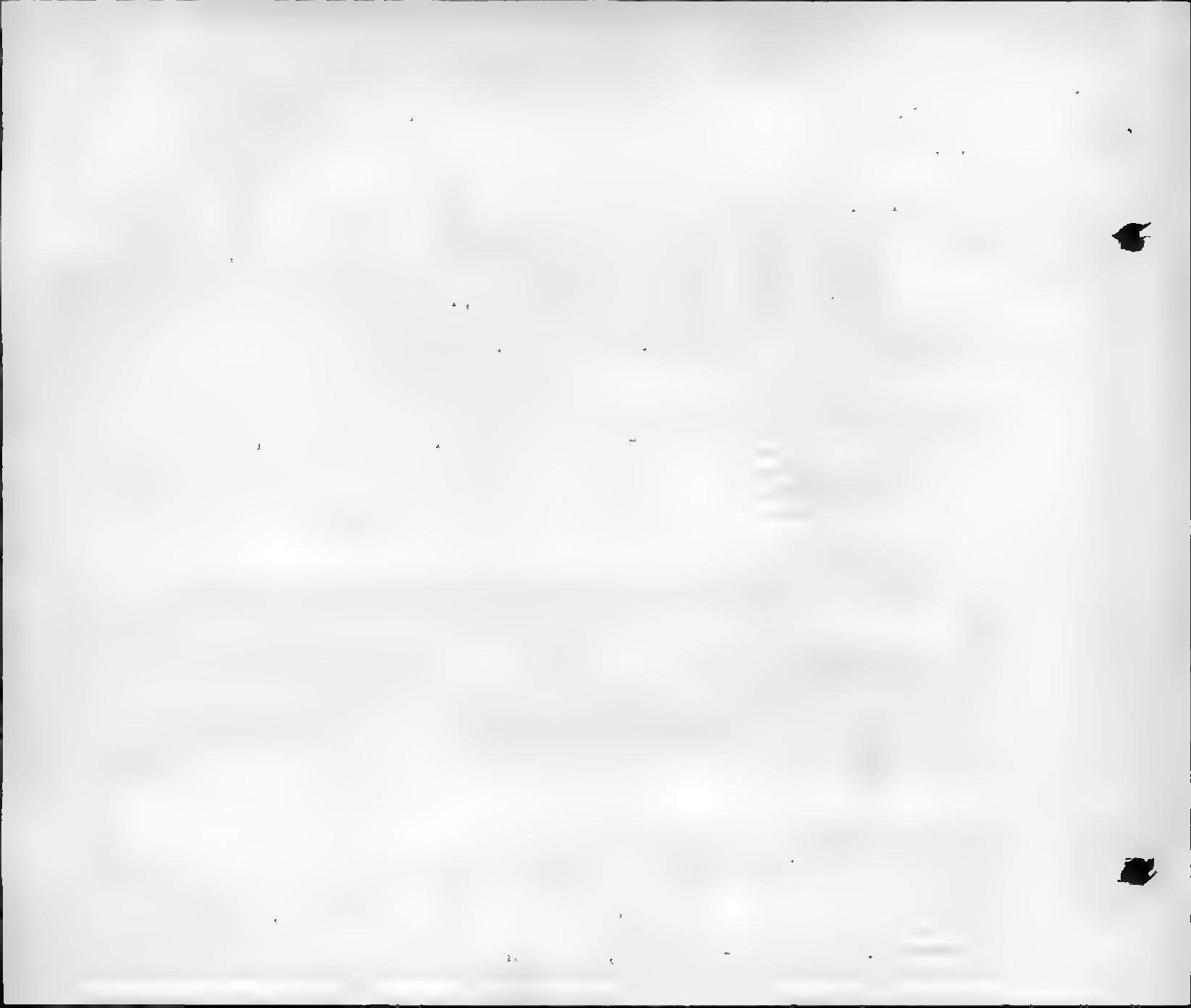
07035

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Montgomery				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 215 Harrison Street				d. STREET ADDRESS 215 Harrison Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First WALTER	Middle STANLEY	Last NICEWARNER	4. DATE OF DEATH June 23,	Month June	Day 23	Year 1958
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 6, 1896	9. AGE (In years last birthday) 62 yrs.	IF UNDER 1 YEAR 1 Months	IF UNDER 24 HRS 17 Days	Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Contractor		10b. KIND OF BUSINESS OR INDUSTRY Building		11. BIRTHPLACE (State or foreign country) W. Virginia		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME James Nicewarner				14. MOTHER'S MAIDEN NAME Malinda Ott				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 218-20-0282		17. INFORMANT Mrs Nellie Nicewarner-Item # 2	Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL THROMBOSIS INTERVAL BETWEEN ONSET AND DEATH 2 MARCH 1958 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) ARTERIAL HYPERTENSION 70 YEARS (c) GENERALIZED ARTERIOSCLEROSIS 70 YEARS								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from MARCH 11, 1958 , to JUN 21, 1958 , that I last saw the deceased alive on JUN 21, 1958 , and that death occurred at 11:15 P.M. from the causes and on the date stated above. ACTUAL SIGNATURE <i>Gordon S. Rosenberger</i> M.D. ADDRESS (Street, city or town, state) 26A Summ. St Apt DATE SIGNED JULY 23, 1958								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/26/58	22c. NAME OF CEMETERY OR CREMATORIAL Rockville		22d. LOCATION (City, town, or county) Rockville, Maryland (State)			
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Maryland		ADDRESS	24a. REC'D BY REGISTRAR DATE JUN 25 1958		24b. REGISTRAR'S SIGNATURE <i>Robert A. Pumphrey</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

(17036)

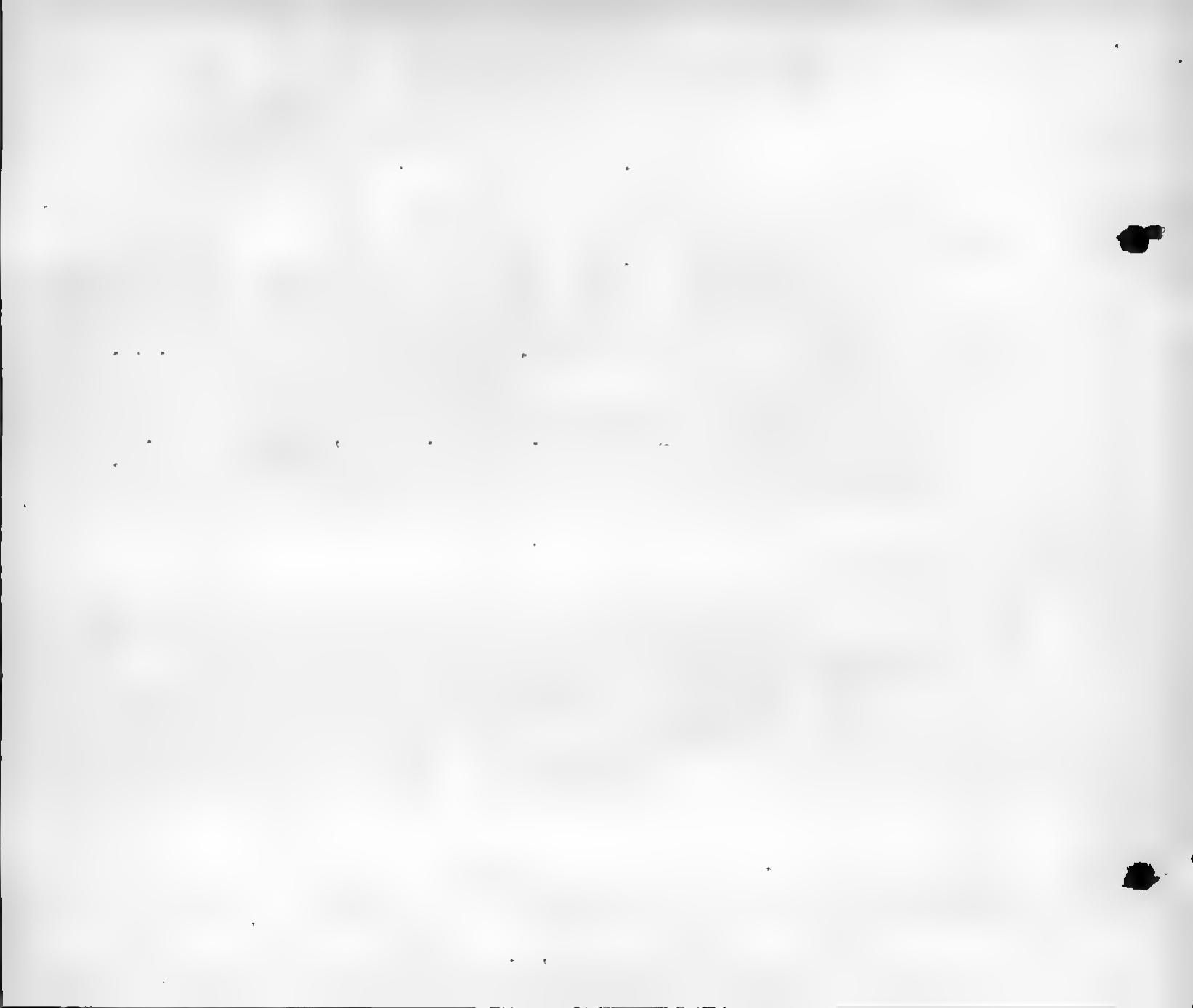
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE MARYLAND					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. LENGTH OF STAY IN 1b 4 yrs.					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 704 McNeill Road		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING					
3. NAME OF DECEASED (Type or print) HOWARD		d. STREET ADDRESS 704 McNeill Road					
First W.		Middle NIPPLE	4. DATE OF DEATH JUNE 8 1958				
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 3/24/74				
		WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MOTORMAN (retired)		10b. KIND OF BUSINESS OR INDUSTRY Capital Transit Co.					
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY U.S.A.					
13. FATHER'S NAME HEZAKIAH NIPPLE		14. MOTHER'S MAIDEN NAME JANE WILHIDE					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO 577-05-7825					
17. INFORMANT Mrs. Elsie M. Burton, 704 McNeill Rd.		Address Silver Spring, Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac Decomposition</i>		INTERVAL BETWEEN ONSET AND DEATH <i>About 5 1/2 yrs</i>					
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last (b) <i>Artherosclerosis</i>		?					
DUE TO (c)							
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Hypertension</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Stab wound</i>					
20c. TIME OF INJURY Hour o. m. p. m.		Month Doy Year 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <i>BURTONSVILLE</i>	(County) <i>MARYLAND</i>	(State)
21. I certify that I attended the deceased from _____, 19_____, to _____, 19_____, that I last saw the deceased alive on _____, 19_____, and that death occurred at _____, 19_____, from the causes and on the date stated above.				ADDRESS (Street, city or town, state) <i>908 Glenville Rd, #150</i>		DATE SIGNED <i>6/11/58</i>	
ACTUAL SIGNATURE <i>William D. Aud</i>		M.D.					
PHYSICIAN'S NAME (Type) WILLIAM D. AUD							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 6/10/58		22c. NAME OF CEMETERY OR CREMATORIUM UNION CEMETERY		22d. LOCATION (City, town, or county) BURTONSVILLE, MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Warren L. Humphrey, SILVER SPRING, MD.</i>		ADDRESS <i>SILVER SPRING, MD.</i>		24a. REC'D BY REGISTRAR DATE <i>JUN 11 '58</i>		24b. REGISTRAR'S SIGNATURE <i>John Smith</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and may be used again.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7052

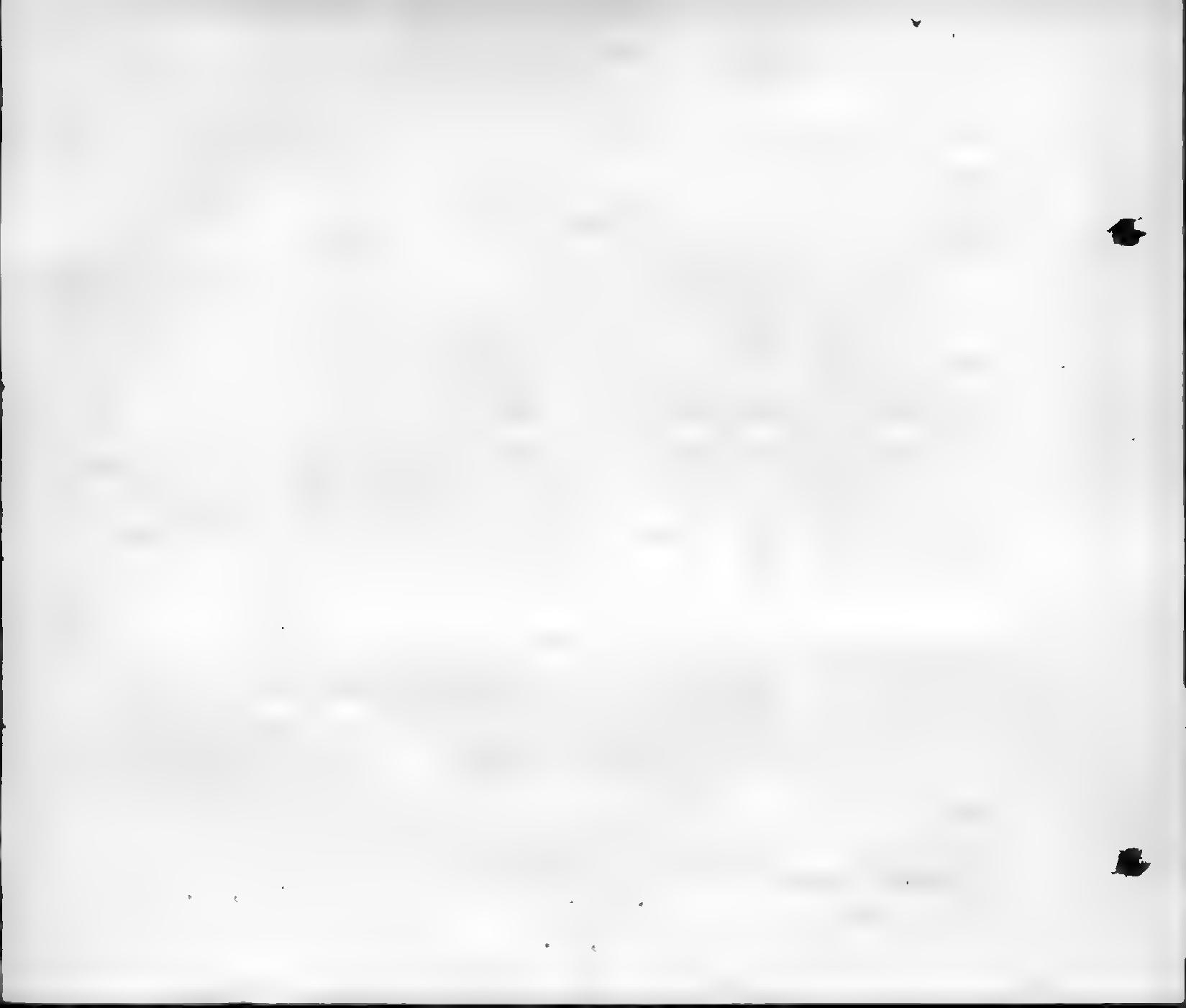
CERTIFICATE OF DEATH

Reg. Dist. No.

17037

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE	
<i>Montgomery Co., Maryland</i>		Md.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		b. COUNTY	
<i>Bethesda Md.</i>		<i>Mont. Co.</i>	
c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
<i>23 days</i>		<i>Box 56 - Fellman, Md.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
<i>Suburban</i>		<i>Fellman, Md.</i>	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First	Middle	Last
<i>Lawrence Claude Onley</i>			
4. DATE OF DEATH	Month	Day	Year
<i>June 2</i>			<i>1958</i>
5. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH
<i>m colored</i>			<i>Oct. 19, 1896</i>
9. AGE (In years last birthday)	10. IF UNDER 1 YEAR	11. IF UNDER 24 HRS.	
<i>61 yrs.</i>	Months	Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY		
<i>Local Minister</i>	<i>Fellman, Md.</i>		
10c. FATHER'S NAME	11. BIRTHPLACE (State or foreign country)		
<i>Henry T. Onley</i>	<i>Fellman, Md. U.S.A.</i>		
12. CITIZEN OF WHAT COUNTRY?			
13. MOTHER'S MAIDEN NAME	<i>Mary Fisher</i>		
14. ADDRESS	<i>Chas. E. Onley-Ld. 58- Fellman, Md.</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	16. SOCIAL SECURITY NO.	17. INFORMANT	18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
<i>No</i>			PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)
			<i>433.0</i>
	DUE TO	<i>Acute Congestive Failure</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.	(b)	<i>2 hours</i>	
	DUE TO	<i>Cardiac Arrest</i>	
	(c)	<i>4 hours</i>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
<i>Generalized Carcinomatosis, Primary Undet.</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II, if item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
<i>May 1958</i>	<i>19</i>	<i>Maryland</i>	<i>Barnesville, Md.</i>
21. I certify that I attended the deceased from <i>May 1958</i> to <i>June 2 1958</i> , that I last saw the deceased alive on <i>June 2 1958</i> , and that death occurred at <i>7:30 PM</i> , from the causes and on the date stated above.	ADDRESS (Street, city or town, state)		
ACTUAL SIGNATURE <i>John P. Haberlin</i>	DATE SIGNED <i>6-2-58</i>		
22a. BURIAL CREMATION, REMOVAL (Specify)	22b. THEREOF	22c. NAME OF CEMETERY OR CREMATORIUM	22d. LOCATION (City, town, or county) (State)
<i>Cremation</i>	<i>1958</i>	<i>Mt. Zion,</i>	<i>Barnesville, Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert L. Surden</i>	ADDRESS <i>Rockville, Md.</i>	24a. REC'D BY REGISTRAR DATE JUN 9 '58	24b. REGISTRAR'S SIGNATURE <i>Al. reade</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician and completely filled in by the funeral director. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the transit permit. Then place carbon copies of page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7053

CERTIFICATE OF DEATH

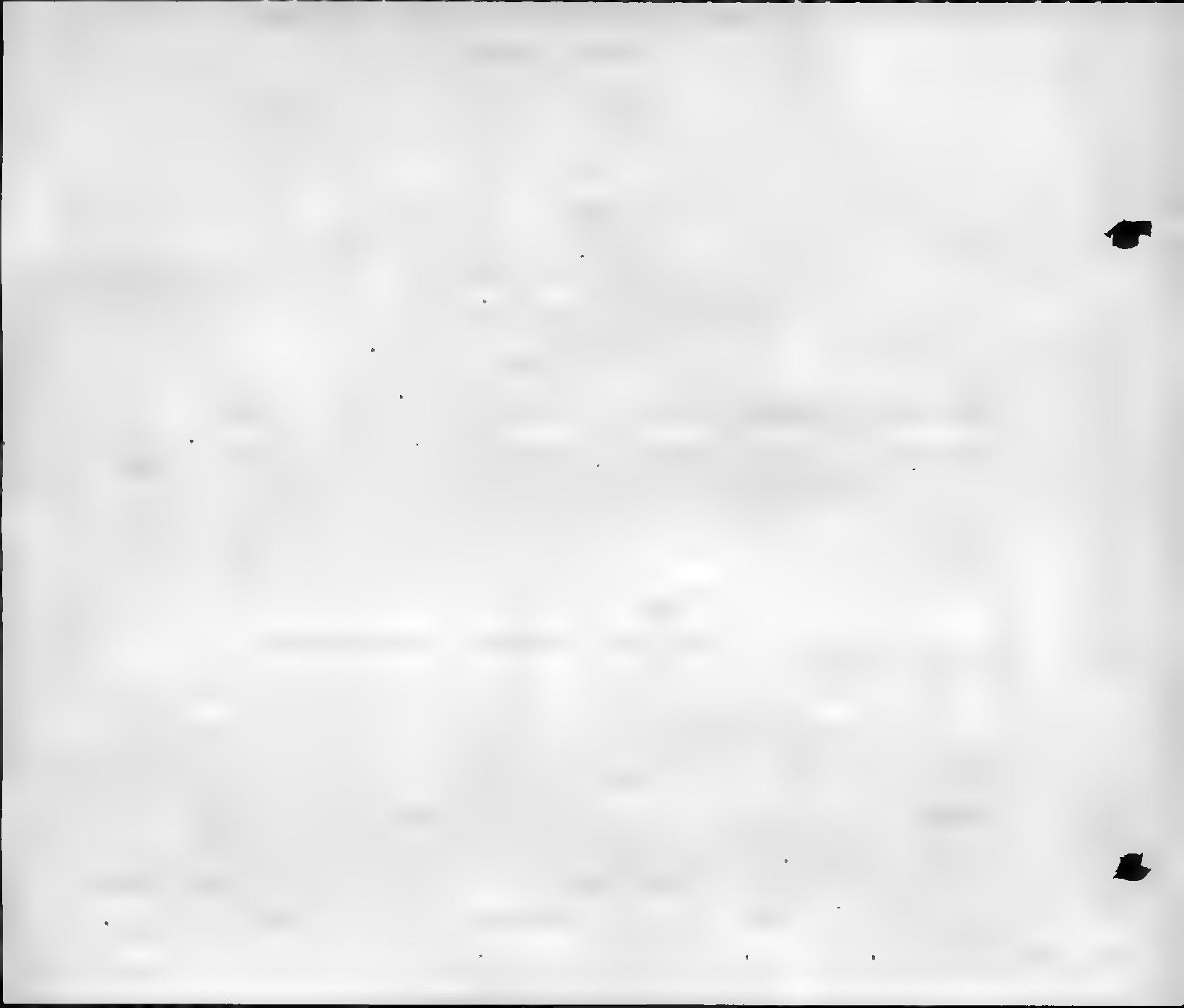
07038

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland		b. COUNTY Montg.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		c. LENGTH OF STAY IN 1b 2 yrs 9 mos		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore Washington, D.C.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Marylander Rest Home		d. STREET ADDRESS 2833 Carroll Ferr, N.W.		e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Pearl	Middle A.	Last Overman	4. DATE OF DEATH June 10	Month Year 1958	Day	Year
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 12-1867	9. AGE (in years lost birthday) 91 yrs.	10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY Home Work		11. BIRTHPLACE (State or foreign country) Clinton, Iowa		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME Henry Arkman		14. MOTHER'S MAIDEN NAME Anna M. Atchinson					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Records, The Marylander, Germantown		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arteriosclerotic cardiovascular disease</i> <i>62.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO cause (c)						INTERVAL BETWEEN ONSET AND DEATH 10 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b.)					
20c. TIME OF INJURY Month, Day, Year Hour o. p. p. m.	19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that I attended the deceased from May 5, 1956, to June 10, 1958, that I last saw the deceased alive on June 9, 1958, and that death occurred at				M, from the causes and on the date stated above		ADDRESS (Street, city or town, state)	
ACTUAL SIGNATURE <i>James P. Kerr</i>	PHYSICIAN'S NAME (Type) James P. Kerr	M.D.	<i>Dovercourt, Md.</i>				DATE SIGNED 6/10/58
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	22b. DATE THEREOF 6-10-58	22c. NAME OF CEMETERY OR CREMATORIAL Ft. Lincoln	22d. LOCATION (City, town, or county) Bladensburg	(State)			
23. FUNERAL DIRECTOR'S SIGNATURE Ernest C. Gartner.	ADDRESS Gaithersburg, Md.	24a. REC'D BY REGISTRAR DUN 11 '58	24b. REGISTRAR'S SIGNATURE <i>Allesieck</i>				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-trust permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7054

CERTIFICATE OF DEATH

07039

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) b. STATE 7111 Woodland Ave., Md.		b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Innwood Gardens Rest Home		d. STREET ADDRESS 7111 Woodland Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Fannie	Middle V.	Last Pack	4. DATE OF DEATH June 27 1958	Month Day Year
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/17/1884	9. AGE (In years less than birthday) 74	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U. S. A.					
13. FATHER'S NAME George S. Burton		14. MOTHER'S MAIDEN NAME Mary S. Utz		Address Takoma Pk. Md.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) (If yes, give war or date of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Walter B. Pack - 7111 Woodland Ave.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH <i>Cong. & valve heart failure</i>			
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) DUE TO (c)		<i>Arteriosclerosis. Cell 202 cc + hypertension 142</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 10, 1958 to June 27, 1958 , that I last saw the deceased alive on June 14, 1958 , and that death occurred at 5:25 P.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state)		DATE SIGNED <i>461 Takoma Rd.apt 7 Silver Spring, MD 20910</i>	
ACTUAL SIGNATURE <i>M.F. Ottman</i>		MD		PHYSICIAN'S NAME (Type) M.F. OTTMAN	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/30/58		22c. NAME OF CEMETERY OR CREMATORIUM Rock Creek Cemetery	
22d. LOCATION (City, town, or county) Washington, D. C.		22e. ADDRESS Washington, D.C.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE The S. H. Eines Co.		24a. REC'D BY REGISTRAR DATE JUN 3 1958		24b. REGISTRAR'S SIGNATURE <i>Abdullah</i>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7055

CERTIFICATE OF DEATH

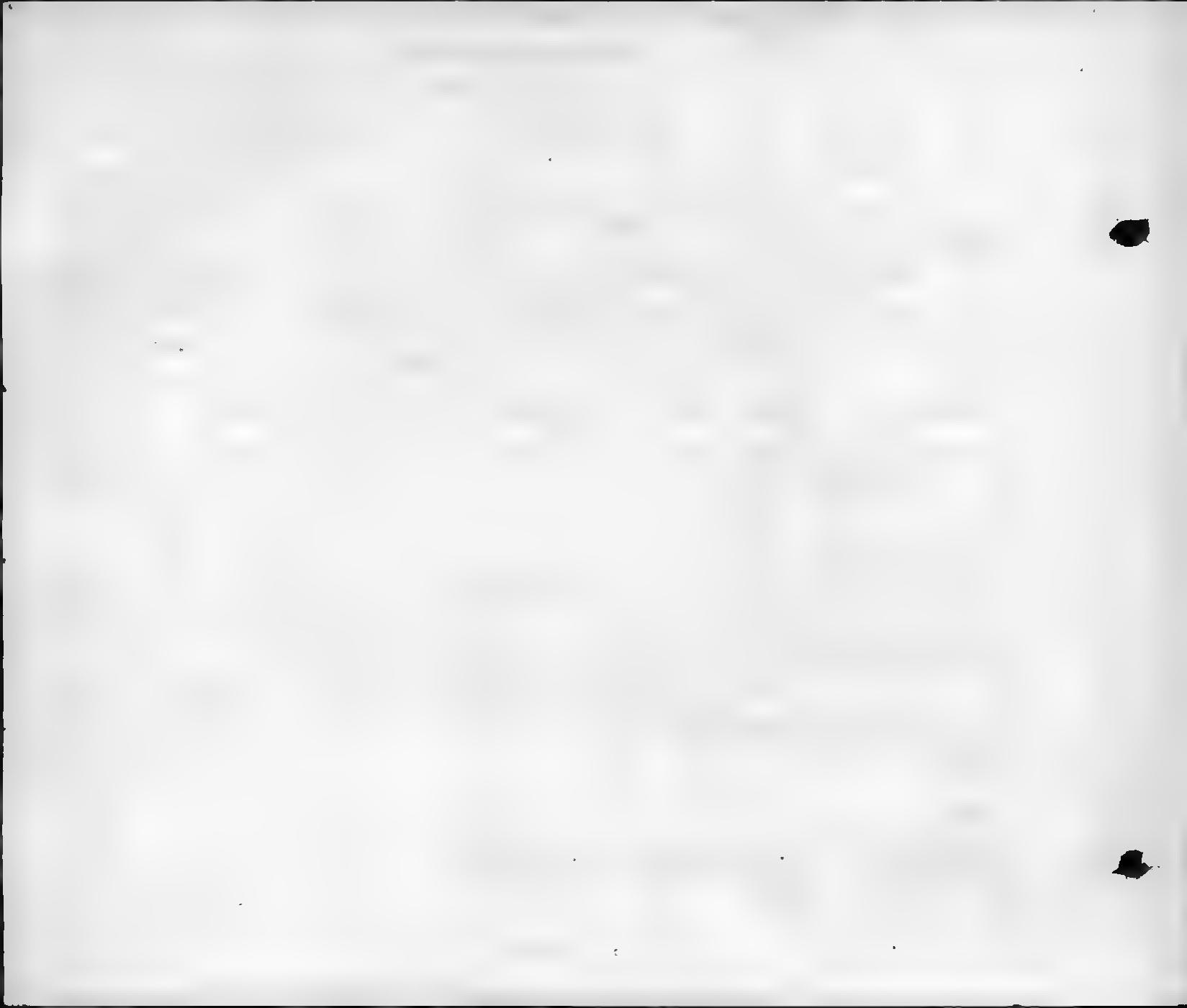
Reg. Dist. No.

07040

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 16 5 days, 2 hrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville	
3. NAME OF DECEASED (Type or print) George Hale		First Middle Last Paterson	4. DATE OF DEATH June 3 1958
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 29, 1966
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) Pet. Rec.		10b. KIND OF BUSINESS OR INDUSTRY Motorcycle A.R.T. dir.	11. BIRTHPLACE (State or foreign country) Kingsbury - Scotland
12. CITIZEN OF WHAT COUNTRY? British		13. FATHER'S NAME JAMES PATERSON	
14. MOTHER'S MAIDEN NAME Margaret Garricoh		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) Yes British	
16. SOCIAL SECURITY NO. None		17. INFORMANT Record F. & Rosenberg - Son-in-law	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) ARTERIAL Sclerosis DUE TO (c) 12/27/1956 HYPERTENSION		INTERVAL BETWEEN ONSET AND DEATH 5 DAYS 10 YEARS 10 YRS 1958	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour e. m. p. m.	Month Day Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 11/17/25, 1958, to 7/14/18, 1958, that I last saw the deceased alive on 7/14/25, 1958, and that death occurred at 1 A. M. from the causes and on the date stated above. ACTUAL SIGNATURE Gordon S. Rosenberg, M.D.		ADDRESS (Street, city or town, state) 26A Summit Way, Rockville, Maryland DATE SIGNED 32-1958	
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 6/5/58	22c. NAME OF CEMETERY OR CREMATORIUM Parklawn Cemetery
22d. LOCATION (City, town or county) Rockville, Maryland		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		24a. ADDRESS Bethesda, Maryland	24b. REC'D BY REGISTRAR DATE JUN 4 '58
		24b. REGISTRAR'S SIGNATURE Alma	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07041

7056

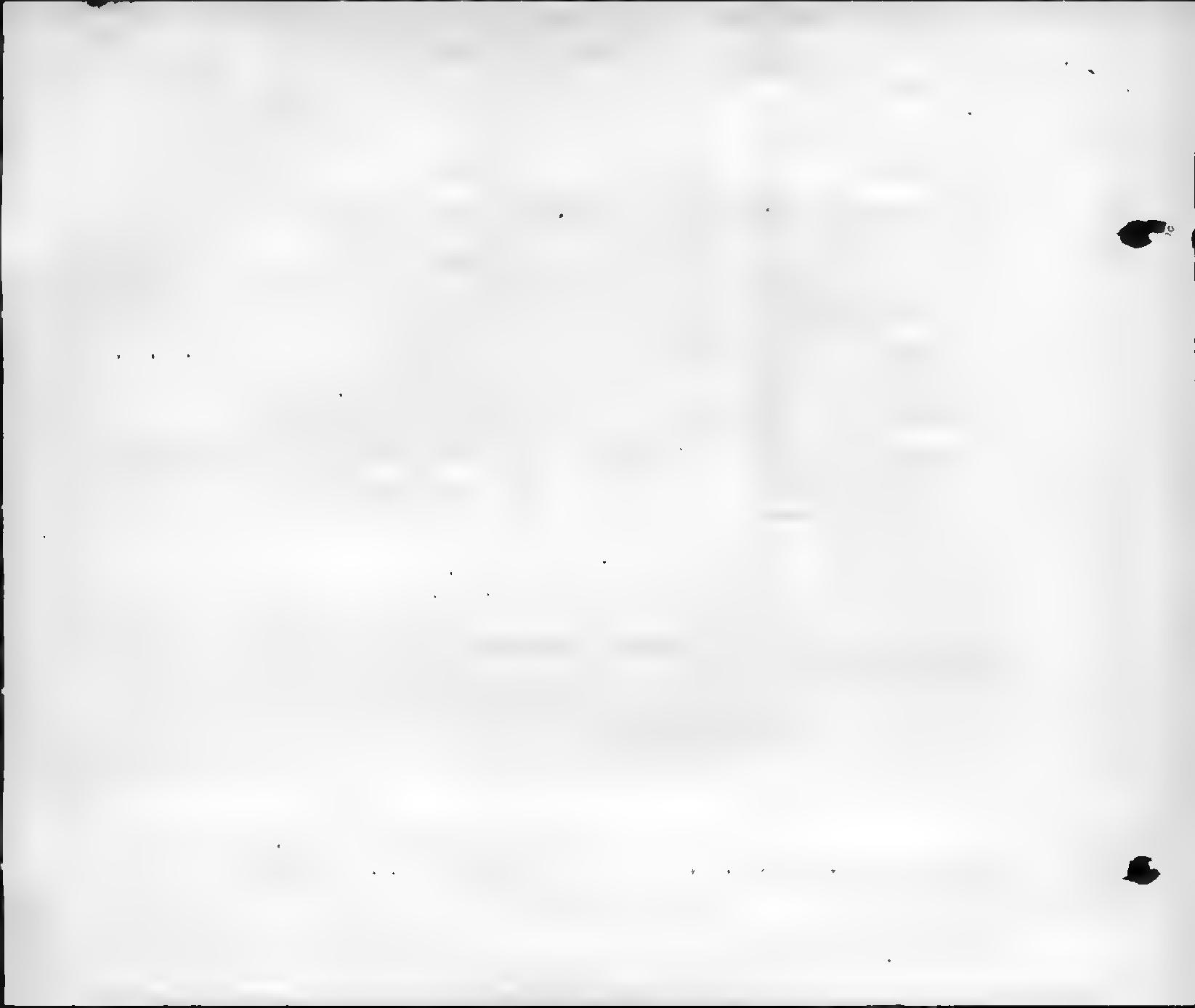
CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 19 days		d. STATE Illinois		b. COUNTY Cook		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chicago		f. STREET ADDRESS 6803 South Michigan Avenue		
3. NAME OF DECEASED (Type or print) Dorothy		First	Middle Lydia	Last Paulson	4. DATE OF DEATH June 8, 1958	Month June	Day 8	Year 1958
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 11, 1911	9. AGE (In years last birthday) 47	10. IF UNDER 1 YEAR OR IF UNDER 24 HRS Months 1	Days 27	Hours Min. 00
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Librarian		10b. KIND OF BUSINESS OR INDUSTRY Library		11. BIRTHPLACE (State or foreign country) Wisconsin		12. CITIZEN OF WHAT COUNTRY? U. S. A.		
13. FATHER'S NAME Nils Brue				14. MOTHER'S MAIDEN NAME Anna Johnson				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. 321-30-6104		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema INTERVAL BETWEEN ONSET AND DEATH: <1 day (3 hrs) Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last (b) 13. L. sick fluctuating DUE TO COPD (CHRONIC OBSTRUCTIVE PULMONARY DISEASE) (c) Edema, and Right heart failure PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 14. Hypertension 15. Diabetes 16. Arteriosclerosis 17. Hypertension 18. Diabetes 19. Arteriosclerosis 20. Hypertension 21. Diabetes 22. Arteriosclerosis 23. Hypertension 24. Diabetes 25. Arteriosclerosis 26. Hypertension 27. Diabetes 28. Arteriosclerosis 29. Hypertension 30. Diabetes 31. Arteriosclerosis 32. Hypertension 33. Diabetes 34. Arteriosclerosis 35. Hypertension 36. Diabetes 37. Arteriosclerosis 38. Hypertension 39. Diabetes 40. Arteriosclerosis 41. Hypertension 42. Diabetes 43. Arteriosclerosis 44. Hypertension 45. Diabetes 46. Arteriosclerosis 47. Hypertension 48. Diabetes 49. Arteriosclerosis 50. Hypertension 51. Diabetes 52. Arteriosclerosis 53. Hypertension 54. Diabetes 55. Arteriosclerosis 56. Hypertension 57. Diabetes 58. Arteriosclerosis 59. Hypertension 60. Diabetes 61. Arteriosclerosis 62. Hypertension 63. Diabetes 64. Arteriosclerosis 65. Hypertension 66. Diabetes 67. Arteriosclerosis 68. Hypertension 69. Diabetes 70. Arteriosclerosis 71. Hypertension 72. Diabetes 73. Arteriosclerosis 74. Hypertension 75. Diabetes 76. Arteriosclerosis 77. Hypertension 78. Diabetes 79. Arteriosclerosis 80. Hypertension 81. Diabetes 82. Arteriosclerosis 83. Hypertension 84. Diabetes 85. Arteriosclerosis 86. Hypertension 87. Diabetes 88. Arteriosclerosis 89. Hypertension 90. Diabetes 91. Arteriosclerosis 92. Hypertension 93. Diabetes 94. Arteriosclerosis 95. Hypertension 96. Diabetes 97. Arteriosclerosis 98. Hypertension 99. Diabetes 100. Arteriosclerosis 101. Hypertension 102. Diabetes 103. Arteriosclerosis 104. Hypertension 105. Diabetes 106. Arteriosclerosis 107. Hypertension 108. Diabetes 109. Arteriosclerosis 110. Hypertension 111. Diabetes 112. Arteriosclerosis 113. Hypertension 114. Diabetes 115. Arteriosclerosis 116. Hypertension 117. Diabetes 118. Arteriosclerosis 119. Hypertension 120. Diabetes 121. Arteriosclerosis 122. Hypertension 123. Diabetes 124. Arteriosclerosis 125. Hypertension 126. Diabetes 127. Arteriosclerosis 128. Hypertension 129. Diabetes 130. Arteriosclerosis 131. Hypertension 132. Diabetes 133. Arteriosclerosis 134. Hypertension 135. Diabetes 136. Arteriosclerosis 137. Hypertension 138. Diabetes 139. Arteriosclerosis 140. Hypertension 141. Diabetes 142. Arteriosclerosis 143. Hypertension 144. Diabetes 145. Arteriosclerosis 146. Hypertension 147. Diabetes 148. Arteriosclerosis 149. Hypertension 150. Diabetes 151. Arteriosclerosis 152. Hypertension 153. Diabetes 154. Arteriosclerosis 155. 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Hypertension 486. Diabetes 487. Arteriosclerosis 488. Hypertension 489. Diabetes 490. Arteriosclerosis 491. Hypertension 492. Diabetes 493. Arteriosclerosis 494. Hypertension 495. Diabetes 496. Arteriosclerosis 497. Hypertension 498. Diabetes 499. Arteriosclerosis 500. Hypertension								
ACTUAL SIGNATURE <i>S. Kahn</i>		PHYSICIAN'S NAME (Type) S. Kahn, M. D.		M.D. The Clinical Center The National Institutes of Health Bethesda 14, Maryland		DATE SIGNED 6/9/58		
220. BURIAL, CREMATION, REMOVAL (Specify) Hur-Transit		221. DATE THEREOF 6/10/58		222. NAME OF CEMETERY OR CREMATORIUM Norway Grove Cemetery		223. LOCATION (City, town, or county) (State) DeForest, Wisconsin		
224. FUNERAL DIRECTOR'S SIGNATURE <i>Robert A. Murphy</i>		ADDRESS Bethesda, Maryland		225. REC'D BY REGISTRAR JUN 10 '58		226. REGISTRAR'S SIGNATURE <i>Albert J. Schaefer</i>		



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any detail is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PHQ. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 24 hours after death.

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
7057 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07042

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery	MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Montg.							
b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) Olney	c. LENGTH OF STAY IN lb D.O.A.	e. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) Monrovia (rural) R-1							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Montg. Co. General Hospital	jd. STREET ADDRESS Claggetsville	e. IS RESIDENT ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) Mary Catherine Peach	First Middle	lost 4. DATE OF DEATH June 21, 1958							
5. SEX female	6. COLOR OR RACE col.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/17/1918	9. AGE (in years from birthday) 39 yrs	10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	11. IF UNDER 24 HRS Months 0 Days 0 Hours 0 Min. 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housemaid		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? USA				
13. FATHER'S NAME Arthur Peach		14. MOTHER'S MAIDEN NAME Elizabeth Bowie							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO 217-30-5903		17. INFORMANT William W. Thomas, Monrovia, Md.	Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH							
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 971.8		Alcohol "Bark turned red owing							
Conditions, if any, which gave rise to immediate cause (a), showing the underlying cause last. (b)		DUE TO							
(c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		Reported to have taken an overdose of sleeping pills							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Hour e. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) New Market, Md.	(County)	(State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <i>Frank J. Broschart</i>	MD CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			DATE SIGNED 6/22/58					
EXAMINER'S NAME (Type) Frank J. Broschart									
22a. BURIAL, CREMATION, OR REMOVAL (Specify) Burial	22b. DATE THEREOF June 24, 1958	22c. NAME OF CEMETERY OR CREMATORIUM Simpson Chapel	22d. LOCATION (City, town, or county) New Market, Md.	(State)					
23. FUNERAL DIRECTOR'S SIGNATURE <i>Elm L. Molsworth</i>	ADDRESS Damascus, Md.	24a. REC'D BY REGISTRAR JUN 25 '58	24b. REGISTRAR'S SIGNATURE <i>Albert Leach</i>						



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6954

CERTIFICATE OF DEATH

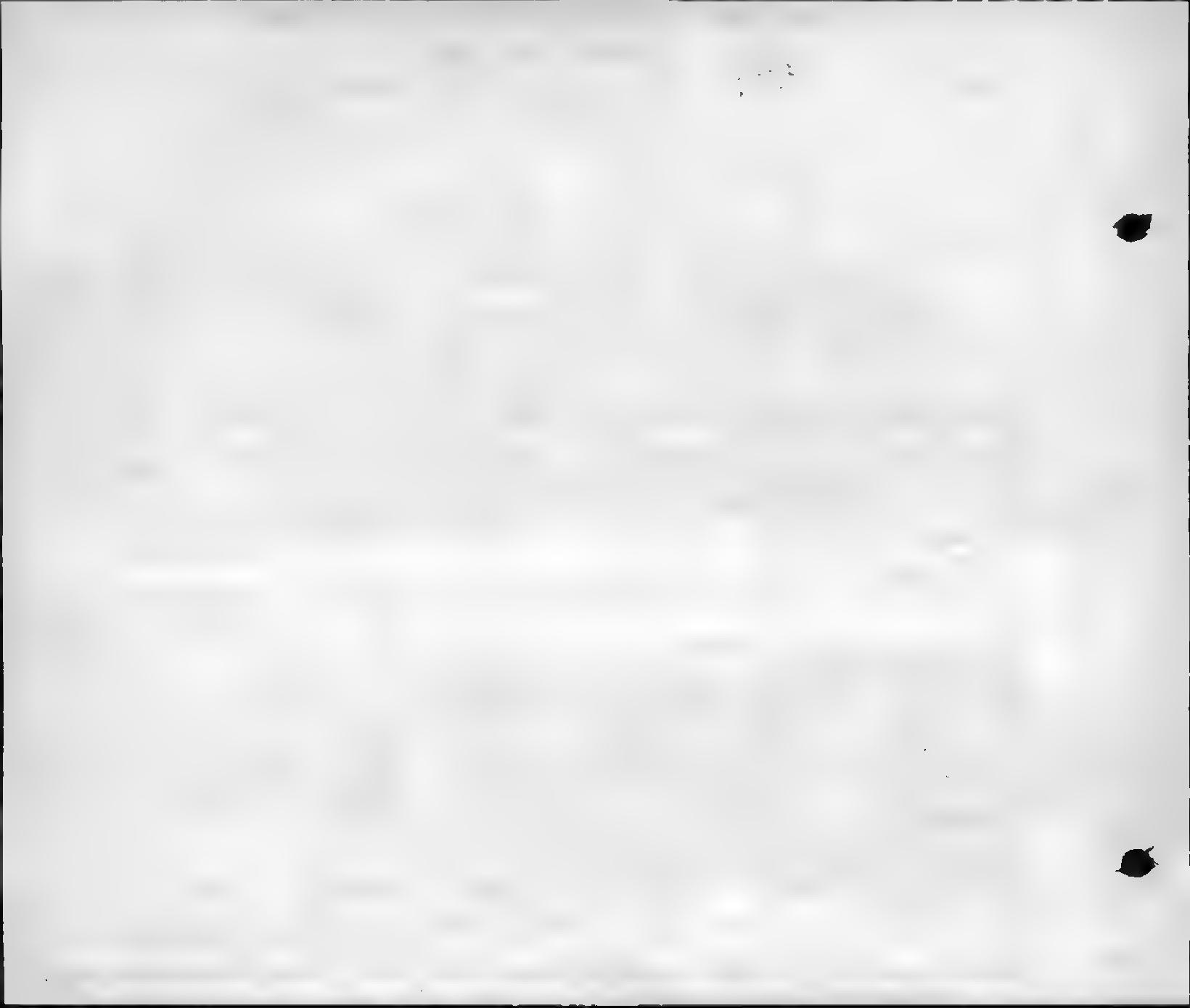
07043

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Montgomery</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		c. LENGTH OF STAY IN lb <i>1 day</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>		d. STREET ADDRESS <i>301 Springbrook Drive</i>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Washington San. & Hosp.</i>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <i>Edna</i>		First <i>Edna</i>	Middle <i>Nmn</i>	Last <i>Burkina</i>	4. DATE OF DEATH <i>JUNE 23 1958</i>	Month <i>JUNE</i>	Day <i>23</i>	Year <i>1958</i>
5. SEX <i>Female</i>		6. COLOR OR RACE <i>white</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>10-15-94</i>		9. AGE (in years from birthday) <i>63 yrs.</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Russia</i>		12. CITIZEN OF WHAT COUNTRY? <i>Amer.</i>		
13. FATHER'S NAME <i>Benjamin Stein</i>		14. MOTHER'S MAIDEN NAME <i>Naomi Chalip</i>		Address				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Medical records</i>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) <i>myocardial infarction</i> DUE TO (c) <i>coronary occlusion</i>								
INTERVAL BETWEEN ONSET AND DEATH <i>5 min</i>								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)								
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, off ce bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <i>July</i> , 1958, to <i>June 23</i> , 1958, that I last saw the deceased alive on <i>June 23</i> , 1958, and that death occurred at <i>2:45 P.M.</i> from the causes and on the date stated above								
ADDRESS (Street, city or town, state) <i>100 Lexington St. W. Wash D.C. 6/23/58</i>								
DATE SIGNED <i>6/23/58</i>								
ACTUAL SIGNATURE <i>Edna C. Wilner</i>		M.D. <i>100 Lexington St. W. Wash D.C. 6/23/58</i>						
PHYSICIAN'S NAME (Type)								
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		22b. DATE THEREOF <i>6/23/58</i>		22c. NAME OF CEMETERY OR CREMATORIAL <i>HAR NEBO CEM.</i>		22d. LOCATION (City, town, or county) <i>PHILA. PA.</i>		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Young Funeral Home</i>		ADDRESS <i>421792 Hwy</i>		24a. REC'D BY REGISTRAR DATE <i>25 58</i>		24b. REGISTRAR'S SIGNATURE <i>Alfred</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07044

7058

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Md.</i>		b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		c. LENGTH OF STAY IN lb <i>6hrs.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>13203 Okinawa Ave.</i>		d. STREET ADDRESS <i>Rockville, Md.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Suburban</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <i>Diana</i>	Middle <i>S</i>	Last <i>Petrey</i>	4. DATE OF DEATH <i>June 25 1958</i>	Month <i>June</i>	Day <i>2</i>	Year <i>1958</i>
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>June 25 1914</i>	9. AGE (In years last birthday) <i>43 yrs</i>	10. IF UNDER 1 YEAR Months <i>11</i>	11. IF UNDER 24 HRS Days <i>7</i>	12. Hours Min. <i></i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Own home</i>		11. BIRTHPLACE (State or foreign country) <i>South Carolina</i>		12. CITIZEN OF WHAT COUNTRY? <i>US</i>	
13. FATHER'S NAME <i>Augustus Fitch O'Brien</i>		14. MOTHER'S MAIDEN NAME <i>Jary Jane Coleman</i>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or No, known) <i>No</i>		16. SOCIAL SECURITY NO <i>226-26-3186</i>		17. INFORMANT <i>Mr. Marshel Petrey</i> Husband--same as 2d		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO Conditions if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c)		<i>Diabetic Coma</i>				INTERVAL BETWEEN ONSET AND DEATH <i>1 day</i>	
		<i>Diabetes Mellitus</i>				10 years +	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour e. m. p. m. <i>19</i>		20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i></i>		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19_____, to _____, 19_____, that I last saw the deceased alive on _____, 19_____, and that death occurred at _____, M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>120 Farnsworth - 17th St. N.W. Washington, D.C.</i>						DATE SIGNED <i>6-25-58</i>	
ACTUAL SIGNATURE <i>A. P. Andrews</i>							
PHYSICIAN'S NAME (Type) <i>P. P. Andrews</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>6/5/58</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>Arlington Cemetery</i>		22d. LOCATION (City, town, or county) <i>Arlington, Virginia</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert A. Humphrey</i>		ADDRESS <i>Bethesda, Maryland</i>		24a. REC'D BY REGISTRAR <i>JUN 6 58</i>		24b. REGISTRAR'S SIGNATURE <i>Robert A. Humphrey</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: This form requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07045

CERTIFICATE OF DEATH

Reg. Dist. No.

7059

1. PLACE OF DEATH
a. COUNTY

Montgomery

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Bethesda

c. LENGTH OF STAY IN lb

4 days

d. NAME OF HOSPITAL (If not in hospital, give street address)
OR INSTITUTION

The Clinical Center, Bethesda 14, Md.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE

District of Columbia

b. COUNTY

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Washington 20

d. STREET ADDRESS

1201 Trenton Place, S.E.

e. IS RESIDENCE
ON A FARM?YES NO 3. NAME OF
DECEASED
(Type or print)

First

Middle

Last

4. DATE
OF
DEATHMonth
JuneDay
12Year
1958

5. SEX

6. COLOR OR RACE

7. MARRIED NEVER MARRIED

8. DATE OF BIRTH

9. AGE (In years
last birthday)10. IF UNDER 1 YEAR
IF UNDER 24 HRS

Male

White

WIDOWED DIVORCED

24 December 1953

4 yrs

Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done
during most of working life, even if retired)

Child (none)

10b. KIND OF BUSINESS OR INDUSTRY

None

11. BIRTHPLACE (State or foreign country)

Washington, D.C.

12. CITIZEN OF WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

Donald F. Peyton

14. MOTHER'S MAIDEN NAME

Julia L. Cunningham

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes no or unknown)

(If yes, give war or dates of service)

no

16. SOCIAL SECURITY NO.

none

17. INFORMANT The Medical Record Address

The Clinical Center, Bethesda 14, Maryland

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

Cardiac arrest

INTERVAL BETWEEN
ONSET AND DEATH

35 min

1. 34, d

DUE TO

Conditions, if any, which
gave rise to immediate
cause (a), stating the under-
lying cause last

(b)

Rt. ventricular failure

12 hrs

DUE TO

(c)

Ventricular septal defect, status post-operative congenital

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY
PERFORMED?YES NO

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH
(If either, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m.20d. INJURY OCCURRED
While at work Not while at work 20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I attended the deceased from June 8, 1958, to June 12, 1958, that I last saw the deceased alive on June 12, 1958, and that death occurred at 5:00A.M. from the causes and on the date stated above.

ADDRESS (Street, city or town, state)

DATE SIGNED

6/12/58

ACTUAL
SIGNATUREPHYSICIAN'S
NAME (Type)

James A. McFarland, M. D.

M.D. The Clinical Center

National Institutes of Health
Bethesda 14, Maryland22a. BURIAL, CREMATION,
REMOVAL (Specify)

Burial

22b. DATE THEREOF

6-14-58

22c. NAME OF CEMETERY OR CREMATORIUM

Cedar Hill

22d. LOCATION (City, town or county)

Silver Spring

(State)

23. FUNERAL DIRECTOR'S SIGNATURE

Summers Bros.

24a. REC'D BY REGISTRAR

ADDRESS

1661- Good Hope Rd SE

Wash. DC.

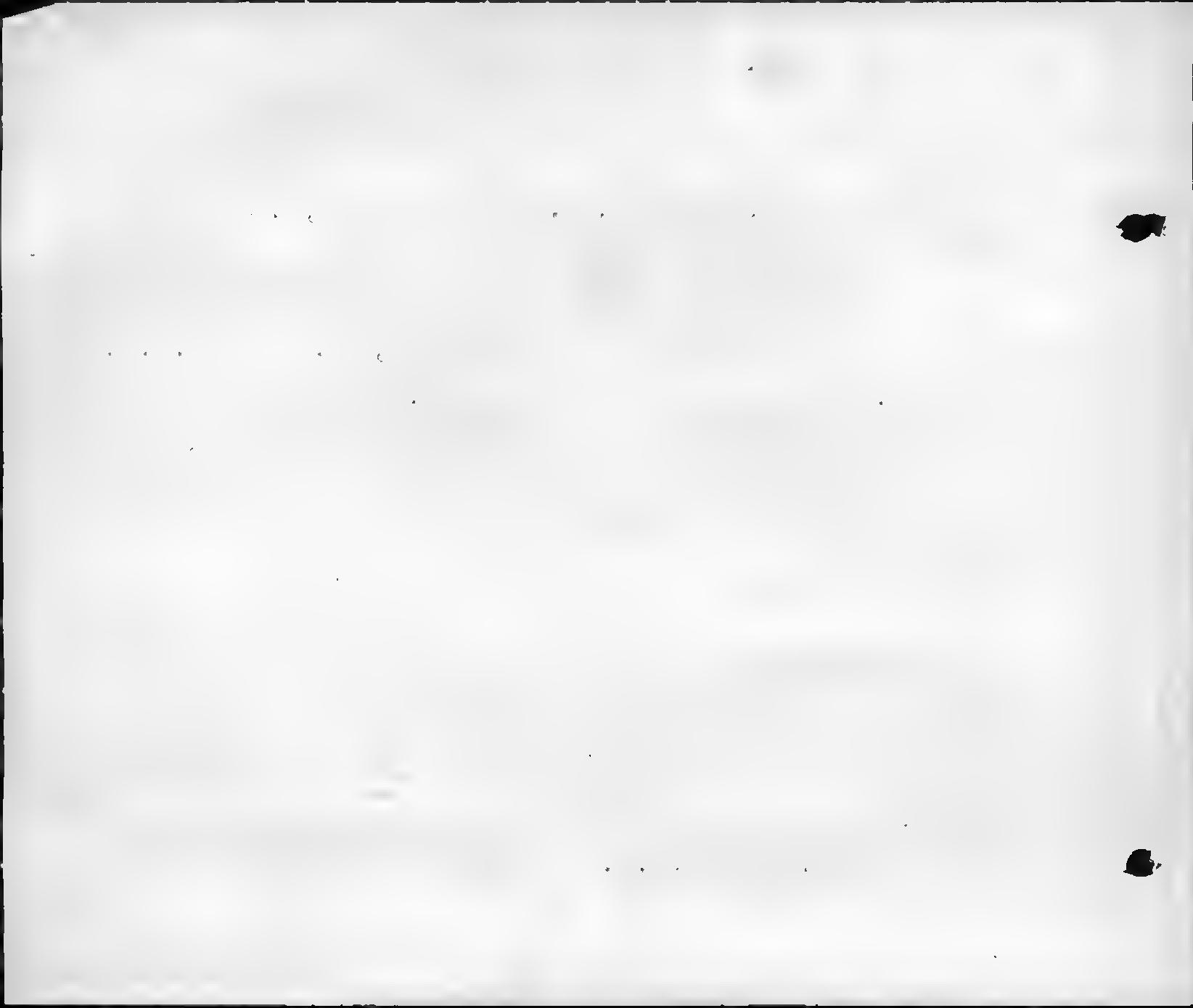
JUN 16 '58

DATE

24b. REGISTRAR'S SIGNATURE

Allen

Leach



07046

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT.

Reg. Dist. No.

1. PLACE OF DEATH

a. COUNTY

Montgomery
 b. CITY OR TOWN (If outside corporate limit, write RURAL
and give nearest town)

c. LENGTH OF STAY IN lb

MARYLAND

2. USUAL RESIDENCE (Where deceased lived if institutional, Residence before admission)

a. STATE

b. COUNTY

c. CITY OR TOWN (If outside corporate limit, write RURAL and give nearest town)

d. STREET ADDRESS

9922 Georgia Ave - Apt 2
 Lot 1 Date of Death June 5 Year 1958

e. IS RESIDENCE
ON A FARM?
YES NO

3. NAME OF
DECEASED
(Type or print)

First

Middle

Pies

4. COLOR OR RACE

male

5. SEX

White

6. MARRIED NEVER MARRIED

WIDOWED

DIVORCED

7. DATE OF BIRTH

1-26-88

8. AGE (In years
and birthday)

70 yrs

9. IF UNDER 1 YEAR
Months Days Hours Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Germany

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

MEDICAL CERTIFICATION

13. FATHER'S NAME

Joseph Pies

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
(If yes, give war or date of service)

No

16. SOCIAL SECURITY NO.

None

17. INFORMANT

Ralph Pease

Address

6207 Wagner Ln

Unit 1A-2C

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY,
IMMEDIATE CAUSE (a)

420.1

DUE TO

Coronary occlusion

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause first.

(b)

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY
PERFORMED?

YES NO

20a. EXTERNAL CAUSE WAS
PRIMARY OR CONTRIBUTING
CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year

Hour a.m.

p.m.

19

20d. INJURY OCCURRED
While at work Not while at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held on Autopsy , Inspection , Inquiry , and in my opinion death resulted from: Natural causes , Accident , Suicide , Homicide , Undetermined manner

ACTUAL
SIGNATURE

FRANK J. Borchart

EXAMINER'S
NAME (Type)

FRANK J. Borchart

DATE SIGNED

6-15-58

22a. BURIAL, CREMATION
REMOVAL (Specify)

Burial

22b. DATE THEREOF

6/9/58

22c. NAME OF CEMETERY OR CREMATORIUM

Gate of Heaven

ADDRESS

Robert A. Pumphrey-Bethesda, Md.

22d. LOCATION (City, town, or county)

Silver Spring, Maryland

(State)

Chesapeake

24a. REC'D BY REGISTRAR

JUN 9 '58

DATE





MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
706 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Req. Dist. No.

07047

DEATH MEDICAL EXAMINER: This certificate shall be executed within 24 hours after death. If any document necessary, please execute it first, writing the word "pending" in pencil in Item 1B. Give Pages 1, 2 and 3 to the medical director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

VS A15MB
5M 2 57

1 PLACE OF DEATH a. COUNTY	Montgomery		MARYLAND	2 USUAL RESIDENCE (If deceased lived in institution or residence before admission)	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give zip/postal code)	Silver Spring		c. LENGTH OF STAY IN 16	b. STATE Maryland	
			8 mos.	b. COUNTY Montgomery	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)			d. STREET ADDRESS Not given		
LeDeau Gardens Nursing Home			LeDeau Gardens Nursing Home		
3. NAME OF DECEASED (Type or print)	First	Middle	4 DATE OF DEATH	Month	Day
Olga Constance Pineau			June 4, 1958		19
5. SEX	6 COLOR OR RACE	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8 DATE OF BIRTH	9 AGE (In years last birthday)	10 IF UNDER 14 YEARS Months Days Hours Min
female	white	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9/22/84	73 yrs	11 IF UNDER 24 YEARS Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
housewife		---		Ill.	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Otto Erickson			Ida Olson		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown)		16. SOCIAL SECURITY NO		17. INFORMANT	
No		None		Address Nursing Home Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Inter Cerebral Hemorrhage</u> 33IX DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Cortical Sclerosis</u> (c)					
INTERVAL BETWEEN ONSET AND DEATH <u>7 1/2 hr</u> <u>years</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERM NAMED SEASSE CONDITION GIVEN IN PART I(a)					
19. WAS AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>Fallen on steps did not contribute to death</u>			
20c. TIME OF INJURY Month, Day, Year 1 PM 45 min 6/4/58 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, off ce bldg., etc.) Home	20f. (City or town) Silver Spring, Montg. Md.	(County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <i>Frank J. Broschart</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			DATE SIGNED June 5, 1958	
EXAMINER'S NAME (Type) Frank J. Broschart					
22a. BURIAL, CREMATION, REMOVAL (Specify) cremation	22b. DATE THEREOF 6/5/58		22c. NAME OF CEMETERY OR CREMATORIUM Cedar Hill Crematory		22d. LOCATION (City, town, or county) Suitland Maryland
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS Robert A. Pumphrey Bethesda, Maryland		24a. REC'D BY REGISTRAR JUN 9 '58	24b. REG STAR'S SIGNATURE <i>Allie Leach</i>



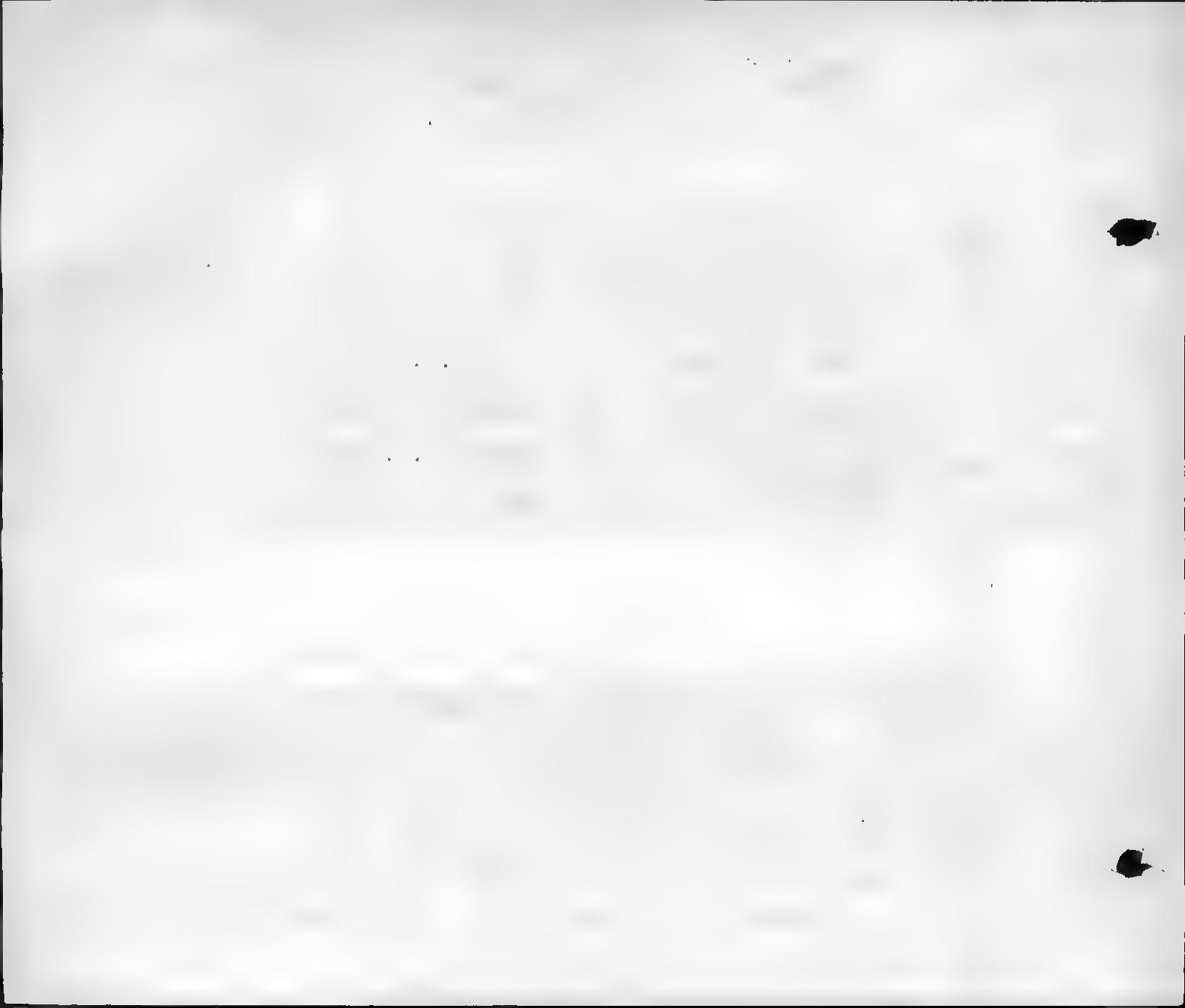
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07048

FOR STATE
HEALTH DERT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any detail is necessary, please execute certificate, writing the word "Pending" in block in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM2. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) a. STATE D. C.		Reg. Dist. No. e. IS RESIDENT ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville		c. LENGTH OF STAY IN 1b 4 hrs			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Woodmont Country Club		d. STREET ADDRESS 2737 Devonshire Place, N. W.		e. DATE OF DEATH June 19, 1958	
3. NAME OF DECEASED (Type or print) Samuel M. Pocker		First	Middle	Year	Month Day
5. SEX male		6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH 1/19/1905	9. AGE (In years from birthday) 53 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Owner of Pocker's Book Shop D.C.		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) N.Y. C.	
13. FATHER'S NAME Max Pocker		14. MOTHER'S MAIDEN NAME Bessie Gratthler		Address	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 420.1 Coronary Occlusion				19. INTERVAL BETWEEN ONSET AND DEATH sudden	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)					
DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <i>Frank J. Broschart</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 6/19/58	
EXAMINER'S NAME (Type) Frank J. Broschart		22c. NAME OF CEMETERY OR CREMATORY Washington Hebrew Cong. Cem.		22d. LOCATION (City, town, or county) Washington D.C.	
22a. BURIAL, CREMATION, OR REMOVAL (Specify) Burial		22b. DATE THEREOF June 22, 1958		24a. REC'D BY REGISTRAR ADDRESS Bernard Danzansky & Sons-3501 14th St., N.W.	
23. FUNERAL DIRECTOR'S SIGNATURE Bernard Danzansky & Sons-3501 14th St., N.W.				24b. REGISTRAR'S SIGNATURE DATE JUN 24 '58	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

07049

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING 16 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 305 WINDSOR STREET		d. STREET ADDRESS 305 WINDSOR STREET	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			

3. NAME OF DECEASED (Type or print)	First HAROLD	Middle RUSSELL	Last PRANGLEY	4. DATE OF DEATH JUNE 25 1958
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5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 9/26/01	9. AGE (In years last birthday) 56 yrs	10. IF UNDER 1 YEAR Months Days Hours Min
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10a. USUAL OCCUPAT. ON (Give kind of work done during most of working life, even if retired) Jeweler	10b. KIND OF BUSINESS OR INDUSTRY Woodward & Lothrop Dept. Store	11. BIRTHPLACE (State or foreign country) ILLINOIS	12. CITIZEN OF WHAT COUNTRY U.S.A.
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13. FATHER'S NAME EMANUEL PRANGLEY	14. MOTHER'S MAIDEN NAME ANNA SCHNEITMAN
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? [Yes, no or unknown] NO	16. SOCIAL SECURITY NO 284-03-3267	17. INFORMANT Mrs. Pauline S. Prangley, 305 Windsor St.	Address Silver Spring, Md.
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18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) - 04-A DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO (c) DUE TO	Cardiac Deletation Cholecystectomy Cholelithiasis	INTERVAL BETWEEN ONSET AND DEATH 3 hours. 2 months 1 year.
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MEDICAL CERTIFICATION	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Exema of Abcess Sub. Diaphragmata	19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
---	--

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
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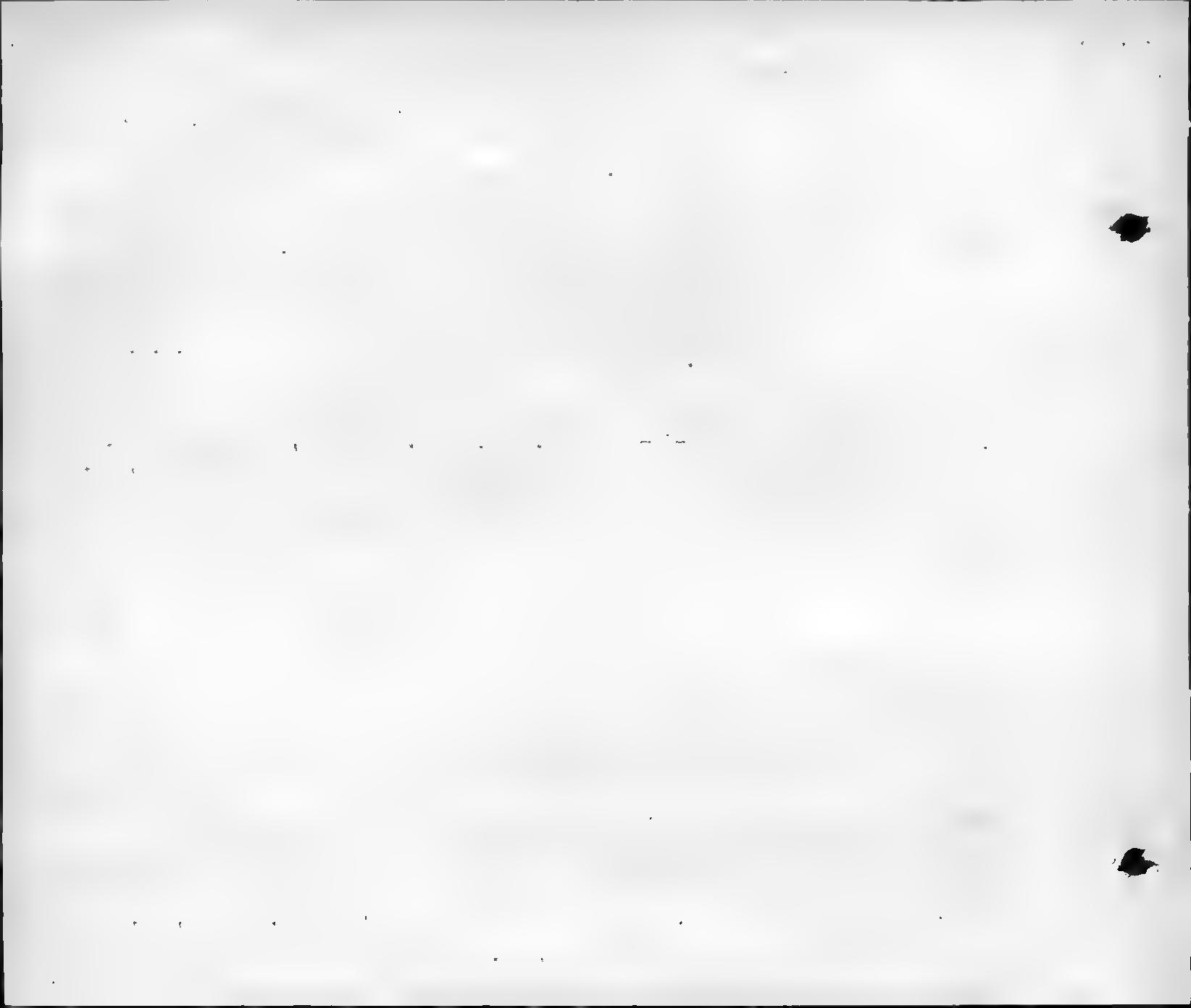
21. I certify that I attended the deceased from January 30 1958, to June 25, 1958, that I last saw the deceased alive on June 25, 1958, and that death occurred at 2:30 AM, from the causes and on the date stated above
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ACTUAL SIGNATURE W.B. WARDROP M.D.	ADDRESS (Street, city or town, state) 837 Bonfant St. Silver Spring, Md.	DATE SIGNED 3/2/58
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PHYSICIAN'S NAME (Type) W.B. WARDROP	22a. LOCATION (City, town, or county) PRINCE GEO. COUNTY, MD.
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22b. BURIAL CREMATION, REMOVAL (Specify) ENTOMBMENT	22b. DATE THEREOF 6/27/58	22c. NAME OF CEMETERY OR CREMATORIUM FT. LINCOLN CEMETERY	22d. LOCATION (City, town, or county) PRINCE GEO. COUNTY, MD.
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23. FUNERAL DIRECTOR'S SIGNATURE Warren E. Pumphrey,	ADDRESS SILVER SPRING, MD.	24a. REC'D BY REGISTRAR JUN 27 '58	24b. REGISTRAR'S SIGNATURE Alv. Research
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

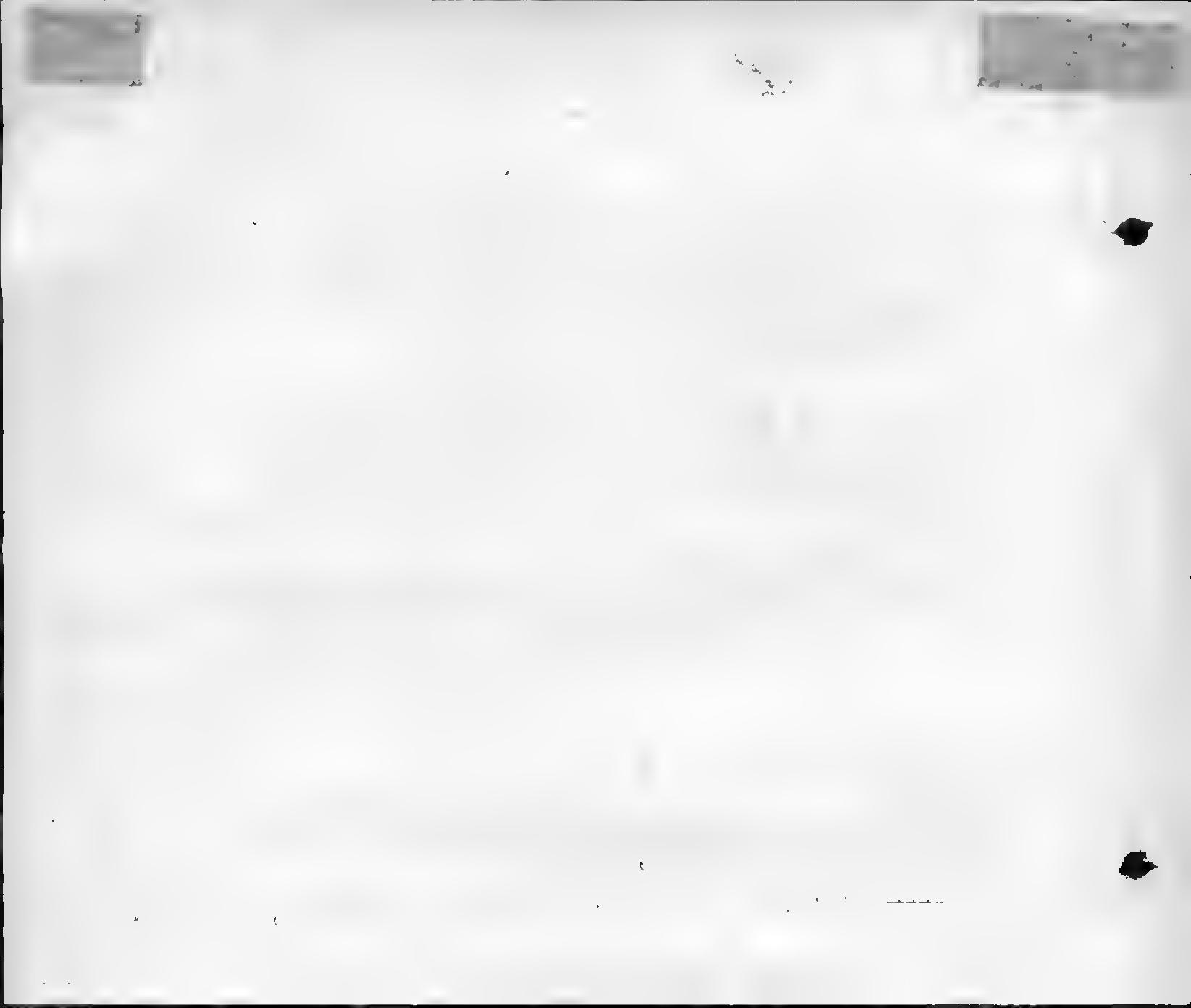
6955

CERTIFICATE OF DEATH

07055

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park, Md.</i>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Chevy Chase</i>							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Washington Sanitarium & Hospital 4600 Drummond Ave.</i>		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print)	First <i>Elise</i>	Middle <i>Emeline</i>	Last <i>Prestcott</i>	4. DATE OF DEATH	Month <i>June</i>	Day <i>8</i>	Year <i>1958</i>				
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Feb. 21, 1925</i>	9. AGE (In years last birthday) <i>33 yrs</i>	10. IF UNDER 1 YEAR IF UNDER 24 HRS Months <i>0</i>	Days <i>0</i>	Hours <i>0</i>	Min <i>0</i>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Colo.</i>		12. CITIZEN OF WHAT COUNTRY? <i>America</i>					
13. FATHER'S NAME <i>Albert E. Keller</i>		14. MOTHER'S MAIDEN NAME <i>Helen Cornish</i>		Address							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Pt's Chart</i>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>686x</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) DUE TO (c)		19. INTERVAL BETWEEN ONSET AND DEATH <i>18 1/2 hrs.</i>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>3994 Baltimore St., Kensington, Md.</i>	20f. (City or town) <i>Suitland</i>	(County) <i>Maryland</i>	(State) <i>MD</i>
21. I certify that I attended the deceased from <i>Jan. 2</i> , 1955, to <i>June 8</i> , 1958, that I last saw the deceased alive on <i>June 8</i> , 1958, and that death occurred at <i>2:30 PM</i> , from the causes and on the date stated above.		ACTUAL SIGNATURE <i>Katharine Chapman, MD</i>		ADDRESS (Street, city or town, state) <i>3994 Baltimore St., Kensington, Md.</i>		DATE SIGNED <i>June 8, 1958</i>					
PHYSICIAN'S NAME (Type) <i>Katharine Chapman, MD</i>		22a. BURIAL, CREMATION, DATE THEREOF REMOVAL <i>CREMATION 6/9/1958</i>		22c. NAME OF CEMETERY OR CREMATORIAL <i>Cedar Hill Crematory</i>		22d. LOCATION (City, town, or county) (State) <i>Suitland, Maryland.</i>					
23. FUNERAL DIRECTOR'S SIGNATURE <i>Joseph J. Weller</i>		ADDRESS <i>1756 Villa, NW DC</i>		24a. REC'D BY REGISTRAR DATE <i>JUN 10 '58</i>		24b. REGISTRAR'S SIGNATURE <i>Albert</i>					



MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

07051

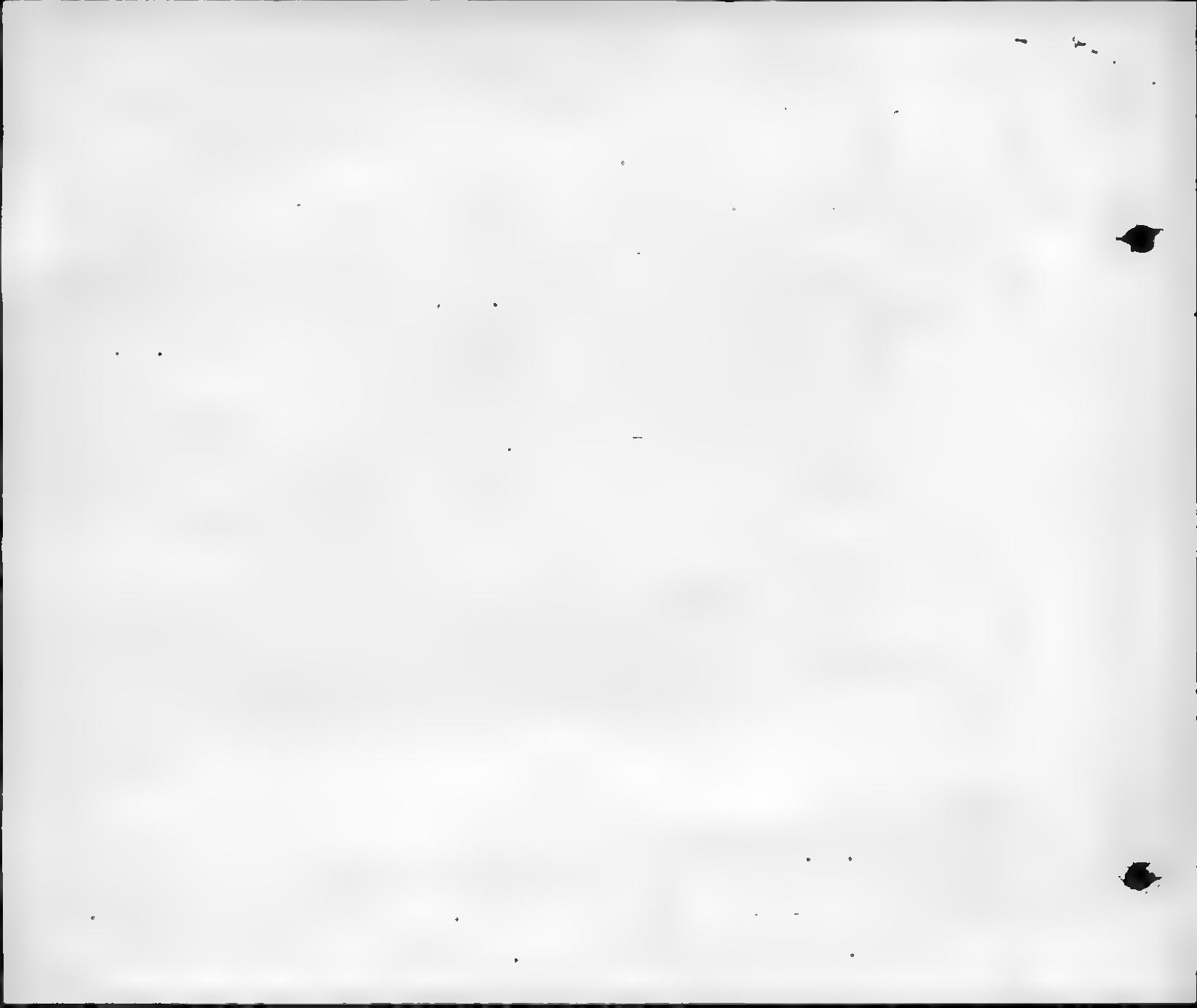
7063

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE [Where deceased lived. If institution, residence before admission] b. STATE Maryland	
		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL Bethesda		c. LENGTH OF STAY IN b 2 1/2 Yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 8519 Pelham Rd.		d. STREET ADDRESS 8519 Pelham Rd.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) MEYER		First MIDDLE --	LAST FUSCHETT
4. DATE OF DEATH June 27,		Month 1958	Day Year
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 19, 1889	
9. AGE (In years last birthday) 68 yrs		10. IF UNDER 1 YEAR Months 8 Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired.		10b. KIND OF BUSINESS OR INDUSTRY New York	
10c. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY U. S.	
13. FATHER'S NAME Jules Puschett		14. MOTHER'S MAIDEN NAME Rachael ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No or unknown) No		16. SOCIAL SECURITY NO 176-24-1479	
17. INFORMANT Daughter Mrs. Ralph Lawrence		Address Same as Item 2.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 DUE TO <i>Cerebral thrombosis</i> Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. } (b) <i>Congestive heart failure c arteriosclerosis 5 yrs.</i> DUE TO } (c) <i>Prior CVA</i>		INTERVAL BETWEEN ONSET AND DEATH <i>Immediate</i> 1946	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>left</i> , 1958, to <i>Janu</i> , 1958, that I last saw the deceased alive on <i>April 30</i> , 1958, and that death occurred at <i>2</i> M. from the causes and on the date stated above. ACTUAL SIGNATURE <i>A. F. Thibaleau</i>		ADDRESS (Street, city or town, state) <i>10116 Coleleville Rd.</i> DATE SIGNED <i>6/27/58</i>	
PHYSICIAN'S NAME (Type) A. F. THIBALEAU		<i>Silver Spring Md.</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial-transit 6-29-58		22b. DATE THEREOF JUN 30 '58	
22c. NAME OF CEMETERY OR CREMATORIUM Beth Israel Cem.		22d. LOCATION (City, town, or county) Luzerne County, Penna.	
23. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY		ADDRESS Bethesda, Md.	
		24a. REC'D BY REGISTRAR DATE	
		24b. REGISTRAR'S SIGNATURE <i>Robert A. Pumphrey</i>	

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the funeral director. His registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6956

CERTIFICATE OF DEATH

Reg. Dist. No.

07052

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 24 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>		MARYLAND		2. USUAL RESIDENCE [Where deceased lived. If institution, Residence before admission on] a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park Md</u>		c. LENGTH OF STAY IN 1b <u>1 day</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San. + Hospital</u>		d. STREET ADDRESS <u>10120 Capital View Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <u>William</u>	Middle <u>Lewis</u>	Last <u>Rabbit Jr.</u>	4. DATE OF DEATH Month <u>6</u>	Day Year <u>28 1958</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/19/98</u>	9. AGE (In years last birthday) <u>59 yrs</u>	10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>JAILOR</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MONT. COUNTY, MD.</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>Amer.</u>					
13. FATHER'S NAME <u>Alfred Robert</u>		14. MOTHER'S MAIDEN NAME <u>MARThA J. KEMP</u>		Address	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO		17. INFORMANT <u>Pts. Hosp. Record</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>350A</u>		DUE TO <u>Anemia - result of a long</u>		INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs.</u>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>anemia</u> (c) <u>rob congestive</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>6-28</u> , 19 <u>58</u> , to <u>6-28</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>6-28</u> , 19 <u>58</u> , and that death occurred at <u>11:15 AM</u> , from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>Abraham L Danst</u>		ADDRESS (Street, city or town, state) <u>927 Pershing St. Silver Spring, Md.</u>		DATE SIGNED <u>6-28-58</u>	
PHYSICIAN'S NAME (Type) <u>ABRAHAM L DANST</u>					
22a. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>7/1/58</u>		22c. NAME OF CEMETERY OR CREMATORIUM <u>ST. JOHN'S CEMETERY</u>	
22d. LOCATION (City, town, or county) <u>MONTGOMERY COUNTY, MARYLAND</u>					
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warren Murphy, Edward Murphy, Inc.</u>		ADDRESS		24a. REC'D BY REGISTRAR DATE <u>JUL 2 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>Debra Smith</u>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07053

7064

CERTIFICATE OF DEATH

Reg. Dist. No.

215

1. PLACE OF DEATH
o. COUNTY

Montgomery

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Bethesda (Rural)c. LENGTH OF STAY IN 1b
4 mos. 12 daysd. NAME OF HOSPITAL (If not in hospital, give street address)
OR INSTITUTION

U.S. Naval Hospital, Bethesda, Md.

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
o. STATE

Virginia

b. COUNTY

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Arlington

d. STREET ADDRESS

2907 N. Edison

e. IS RESIDENCE
ON A FARM?
YES NO 3. NAME OF
DECEASED
(Type or print)First
LewisMiddle
HayesLast
RANDALL4. DATE
OF
DEATHMonth
JuneDay
18
Year
1958

5. SEX

6. COLOR OR RACE

Male

White

7. MARRIED NEVER MARRIED WIDOWED DIVORCED

8. DATE OF BIRTH

9 August 1876

9. AGE (In years
last birthday)

81 yrs.

10. IF UNDER 1 YEAR

Months
Days

11. IF UNDER 24 HRS.

Hours
Min10a. USUAL OCCUPATION (Give kind of work done
during most of working life, even if retired)

Insurance Salesman

10b. KIND OF BUSINESS OR INDUSTRY

Commercial

11. BIRTHPLACE (State or foreign country)

Michigan

12. CITIZEN OF WHAT COUNTRY?

U.S.

13. FATHER'S NAME

Stephen RANDALL

14. MOTHER'S MAIDEN NAME

Lenah JOHNSON

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
(If yes, give war or date of service)

Yes Spanish Am. War.

16. SOCIAL SECURITY NO.

(If yes, give war or date of service)

Unknown

17. INFORMANT

Official Navy Records

Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

Cerebrovascular accident (hemorrhage)

INTERVAL BETWEEN
ONSET AND DEATH

24 hrs.

DUE TO

Conditions, if any, which
gave rise to immediate
cause (a), stating the under-
lying cause last.
(b)

DUE TO

(c)

MEDICAL CERTIFICATION

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY
PERFORMED? YES NO

Carcinoma of Prostate with vertebral metastasis

20a. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF DEATH
(If either, notify medical examiner)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. 1920d. INJURY OCCURRED
While at work Not while at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I attended the deceased from 6 Feb. 1958, to 18 June 1958, that I last saw the deceased alive on 18 June 1958, and that death occurred at 11:20AM, from the causes and on the date stated above.

ADDRESS (Street, city or town, state)

DATE SIGNED

ACTUAL
SIGNATUREPHYSICIAN'S
NAME (Type)

JOHN A LYNCH, LT, MC, USNR

U.S. Naval Hospital, Bethesda, Md.

6-18-58

22a. BURIAL, CREMATION,
REMOVAL (Specify)
Burial

6-22-58

22b. DATE THEREOF
Spring Grove Cemetery22d. LOCATION (City, town, or county)
Medina, Ohio

(State)

23. FUNERAL DIRECTOR'S SIGNATURE

Arlington Funeral Home, 3901 N. Fairfax Dr.

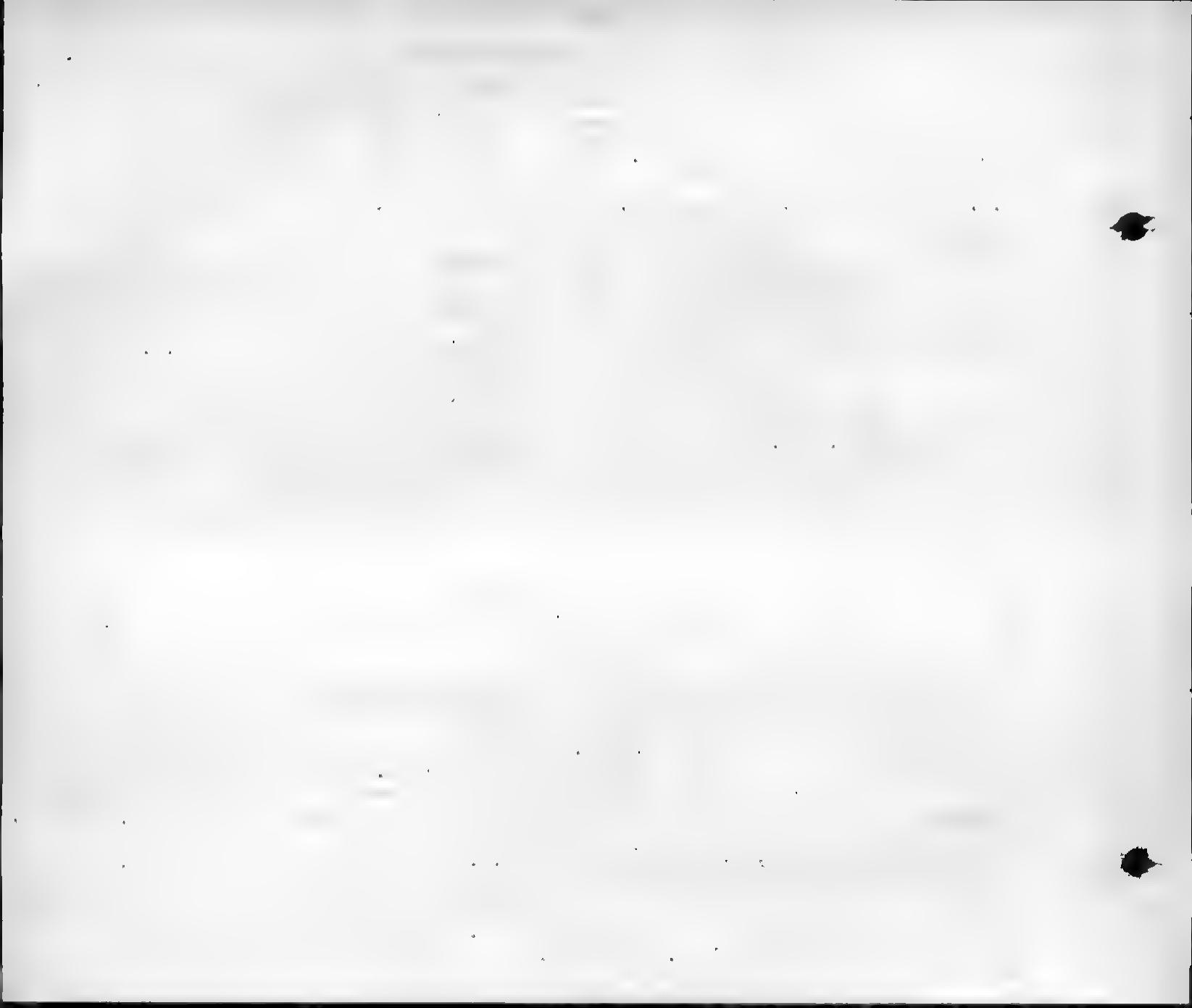
ADDRESS Arlington, Va.

24a. REC'D BY REGISTRAR

DATE JUN 20 '58

24b. REGISTRAR'S SIGNATURE

O. L. Sedgwick



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7065

CERTIFICATE OF DEATH

Reg. Dist. No.

07054

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN lb 2 min.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville	
d. STREET ADDRESS 7401 25th Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Baby	Middle Boy	Last RASMUSSEN
4. DATE OF DEATH	Month June	Day 3	Year 1958
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-2-58
9. AGE (In years last birthday) yrs 2	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0	12. IF UNDER 24 HRS Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY — — —	
10c. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY: U.S.	
13. FATHER'S NAME Johannes L. RASMUSSEN		14. MOTHER'S MAIDEN NAME Helen Marie TUTT	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT (Father) Johannes L. Rasmussen (Same As #2)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).]			
PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 761.0 DUE TO Anemia			
Conditions, if any which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO Fetal dystocia (c)			
INTERVAL BETWEEN ONSET AND DEATH			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. [Enter nature of injury in Part I or Part II of item 18.]	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3 June 1958 to 3 June 1958 , that I last saw the deceased alive on 3 June 1958 , and that death occurred at 10:52A M , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>John H. Mazur</i>		ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md. DATE SIGNED 6-6-58	
PHYSICIAN'S NAME (Type) JOHN H. MAZUR, LT MC USN		U.S. Naval Hospital, Bethesda, Md.	
22a. BURIAL, CREMAT. ON REMOVAL (Specify) Burial		22b. DATE THEREOF 6-9-58	
22c. NAME OF CEMETERY OR CREMATORIUM Arlington Nat'l Cemetery		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Roy J. Humphrey</i>		ADDRESS 7557 Wisconsin Ave., Bethesda, Md.	
		24a. REC'D BY REGISTRAR JUN 9 '58	
		24b. REGISTRAR'S SIGNATURE <i>Reed Leach</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7066

CERTIFICATE OF DEATH

07055
Reg. Dist. No. 215

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be filed with page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 16 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Joseph	First Lee	Middle RHODES	4. DATE OF DEATH Month June Day 13 Year 1958
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 12, 1888
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Scientific Assistant		10b. KIND OF BUSINESS OR INDUSTRY U.S. Dept. Agriculture	11. BIRTHPLACE (State or foreign country) Virginia
13. FATHER'S NAME David H. RHODES		14. MOTHER'S MAIDEN NAME Rachel BELL	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) Yes WWI		16. SOCIAL SECURITY NO None	17. INFORMANT (Son) David H. Rhodes, Brookville Road, Chevy Chase, Md.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Bronchogenic carcinoma</i>		INTERVAL BETWEEN ONSET AND DEATH 12	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO			
(c) DUE TO			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) U.S. Naval Hospital, NNMC
20f. (City or town) Bethesda, Maryland		(County) (State)	
21. I certify that I attended the deceased from May 29, 1958 , to June 13, 1958 , that I last saw the deceased alive on June 13, 1958 , and that death occurred at 4:30 P.M. from the causes and on the date stated above			
ACTUAL SIGNATURE <i>Jerome A. Gold</i>		ADDRESS (Street, city or town, state) U.S. Naval Hospital, NNMC	
PHYSICIAN'S NAME (Type) Jerome A. GOLD, LT, MC, USN		DATE SIGNED 6-14-58	
22o. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-18-58	22c. NAME OF CEMETERY OR CREMATORIAL HOME Arlington National Cemetery, Arlington, Virginia
22d. LOCATION (City, town, or county) Arlington		(State) Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE <i>R. J. Pumphrey, Funeral Home, 7557 Wisconsin Ave. NW</i>		24a. REC'D BY REGISTRAR JUN 16 '58	
		24b. REGISTRAR'S SIGNATURE <i>John J. Deane</i>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7067

CERTIFICATE OF DEATH

07056

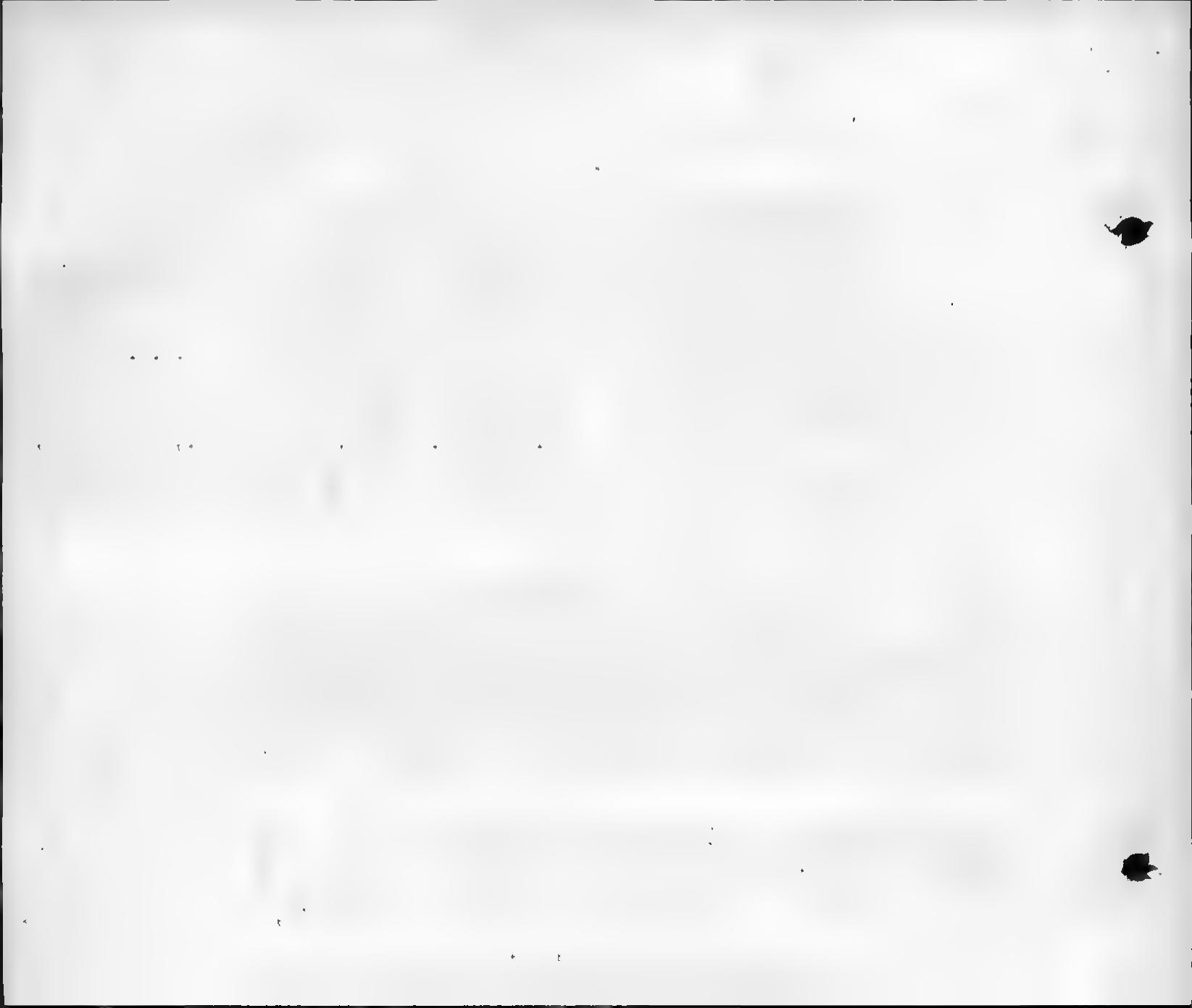
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) COLESVILLE		c. LENGTH OF STAY IN b 5 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 41 SHAW AVENUE		e. STREET ADDRESS 41 SHAW AVENUE	
f. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First ETHEL	Middle BLAKE	Last RICHARDS
4. DATE OF DEATH	Month June	Day 23	Year 1958
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 5/9/77
9. AGE (In years last birthday) 81 yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOMEMAKER		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
11. BIRTHPLACE (State or foreign country) ILLINOIS		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME AARON BENSON BLAKE		14. MOTHER'S MAIDEN NAME MILICENT CULP	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown) NO		16. SOCIAL SECURITY NO NONE	
17. INFORMANT Mrs. Helen R. Sigler, 41 Shaw Ave., Colesville, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 33IX DUE TO		Seizure Vascular accident 1/5 days	
Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. DUE TO		Generalized arteriosclerosis years	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) None		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 14, 1958 to June 23, 1958 , that I last saw the deceased alive on June 14, 1958 , and that death occurred at 11:15 A.M. from the causes and on the date stated above		ADDRESS (Street, city or town, state) Silver Spring, Md. DATE SIGNED June 23, 1958	
ACTUAL SIGNATURE John S. Rogers		M.D. 1912 Seminary Rd.	
PHYSICIAN'S NAME (Type) JOHN S. ROGERS		22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	
22b. DATE THEREOF 6/26/58		22c. NAME OF CEMETERY OR CREMATORIUM COLESVILLE CEMETERY	
22d. LOCATION (City, town, or county) (State) COLESVILLE, MONTGOMERY COUNTY, Md.		24a. REC'D BY REGISTRAR DATE JUN 24 1958	
23. FUNERAL DIRECTOR'S SIGNATURE Warren G. Humphrey, SILVER SPRING, MD.		24b. REGISTRAR'S SIGNATURE Deborah	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

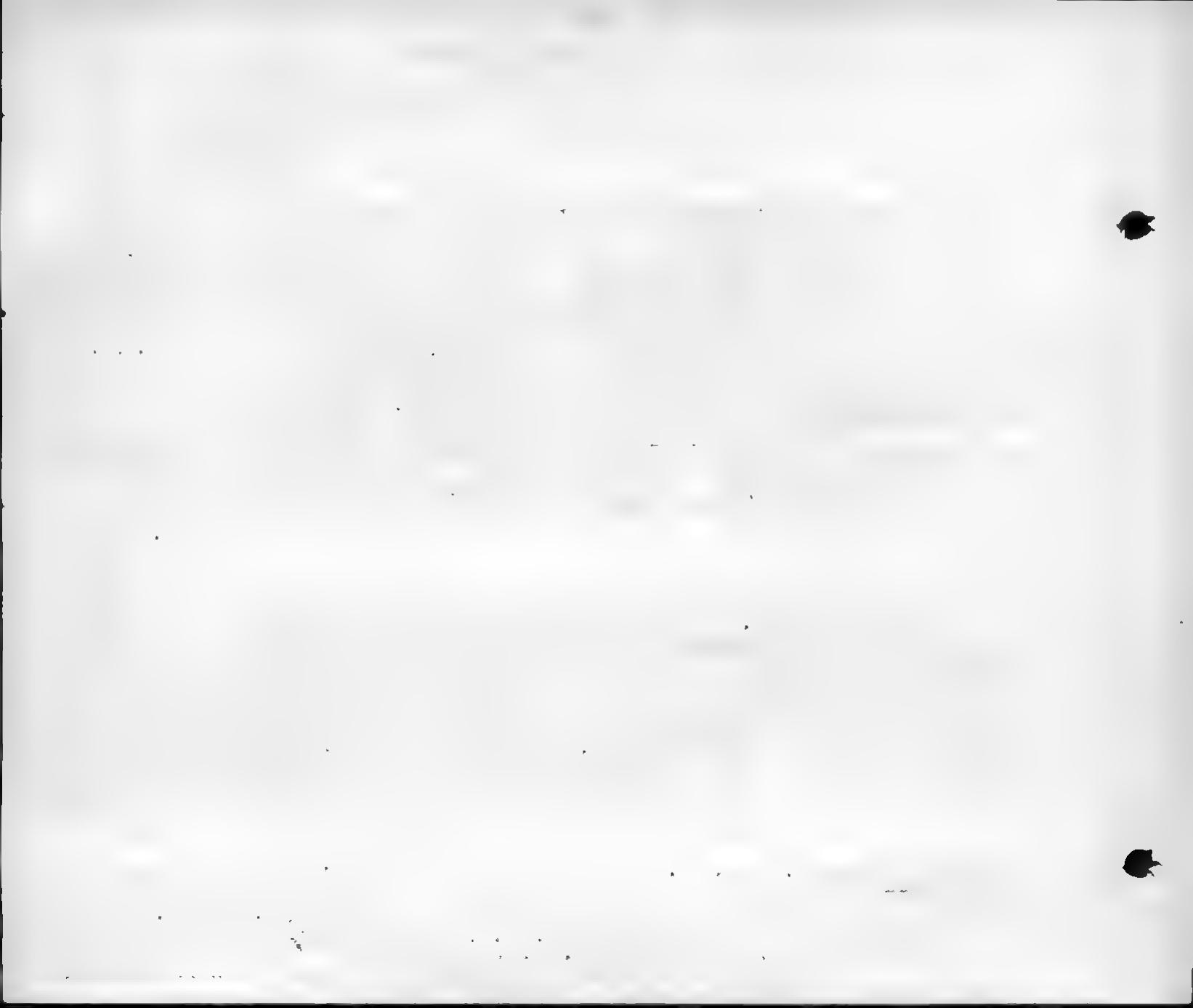
07057

7068

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Pennsylvania		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN lb 41 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Portage			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		d. STREET ADDRESS 407 Johnson Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Summerfield	Middle Jackson	Last Richardson	4. DATE OF DEATH June 19, 1958	Month June	Day 19	Year 1958
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 15, 1903	9. AGE (In years last birthday) 54 yrs	10. IF UNDER 1 YEAR, IF UNDER 24 HRS Months 5 Days 0 Hours 0 Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Coal Miner		10b. KIND OF BUSINESS OR INDUSTRY Mining		11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Richardson		14. MOTHER'S MAIDEN NAME Rachel Greeneway					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) No		16. SOCIAL SECURITY NO. 208-09-1151		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopleural Fistula DUE TO 4 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Lung Abscess DUE TO (c) Pulmonary Emboli INTERVAL BETWEEN ONSET AND DEATH 1 m/o							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Rheumatic Heart Disease & Mitral Valvulitis, old + inactive							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 9, 1958 to June 19, 1958 , that I last saw the deceased alive on June 19, 1958 , and that death occurred at 10:35 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center National Institutes of Health Bethesda 14, Maryland DATE SIGNED 6/20/58							
SIGNATURE Thomas N. Lynn Jr.	MD						
PHYSICIAN'S NAME (Type) Thomas N. Lynn, Jr.							
22a. BURIAL Cremation, REMOVAL (Specify) Removal	22b. DATE THEREOF 6/20/58	22c. NAME OF CEMETERY OR CREMATORIUM		22d. LOCATION (City, town, or county) (State) Portage, Penna.			
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co., 2901 14th St. N.W.	ADDRESS Wash. D.C.	24a. REC'D BY REGISTRAR DATE JUN 23 1958		24b. REC'D STAR SIGNATURE C. G.			



TO DEPUTY MEDICAL EXAMINER: This certificate should be initialed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 7069 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 017058

1. PLACE OF DEATH a. COUNTY Montgomery	MARYLAND	2. USUAL RESIDENCE (Where deceased lived if institution residence before admission) a. STATE Maryland b. COUNTY Montg.					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 5800 Block Wilson Lane	e. STREET ADDRESS 5802 Wilson Lane	f. IS RE. DEP. E. ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Andrew Ralph Ricketts	First A Middle R	4. DATE OF DEATH Month June Day 11 , Year 1958					
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 7/15/57	9. AGE (In years last birthday) yrs 10 mos 26	10. IF UNDER 1 YEAR Months 10 Days 26 Hours Min.	11. IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. C.TIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Ralph Ricketts		14. MOTHER'S MAIDEN NAME Martha Panagopoulos					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (For men, unknown) No		16. SOCIAL SECURITY NO None		17. INFORMANT Police Record		A-201	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage & Laceration DUE TO Conditions, if any, which gave rise to immediate cause (b) Compound Fracture of Skull DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL SEASSE CONDITION GIVEN IN PART I(a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. How XXX p.m. 7:05 6.11/58		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Struck by hit & run auto while in a stroller					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20c. TIME OF INJURY Month, Day, Year July 11, 1958		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) highway	20f. (City or town) Bethesda Montg. Md.	(County) (State)		
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>Frank J. Broschart</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			DATE SIGNED June 11, 1958			
EXAMINER'S NAME (Type) Frank J. Broschart							
22a. BURIAL CREMATION, DATE THEREOF REMOVAL (Specify) Burial 6-14-58	22b. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery			22d. LOCATION (City, town, or county) Montgomery County, Md.			
23. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY	ADDRESS Bethesda, Maryland			24a. REC'D BY REGISTRAR DATE JUN 16 '58			
24b. REGISTRAR'S SIGNATURE <i>Mr. ... Schlesinger</i>							

a

FOR STATE
HEALTH DEPT.

M

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any detail is necessary please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Funeral Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Farm P-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or his designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07059

Reg. Dist. No.

7070

1. PLACE OF DEATH a. COUNTY	Montgomery		MARYLAND	2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission)	Maryland			b. COUNTY	Montg.		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	Bethesda		c. LENGTH OF STAY IN 1b	Bethesda			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	Bethesda			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)	5800 Block Wilson Lane		d STREET ADDRESS	5802 Wilson Lane			e IS RE DENIE ON A FARM?	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First	Middle	Last	4 DATE OF DEATH	Month	Day	Year				
Martha P.		Ricketts		June 11, 1958							
5. SEX	6 COLOR OR RACE	7 MARRIED	NEVER MARRIED	8 DATE OF BIRTH	9 AGE (In years last b. birthday)	10 IF UNDER 1 YEAR	11 IF UNDER 24 HRS				
female	white	<input checked="" type="checkbox"/>	<input type="checkbox"/>	7/5/1938	19 yrs	Months Days	Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	housewife		10b. KIND OF BUSINESS OR INDUSTRY	11 BIRTHPLACE (State or foreign country)			12 CITIZEN OF WHAT COUNTRY?				
				D.C.			USA				
13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME										
Andrew Panagopoulos	Rose Trois										
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO.	17. INFORMANT	Address								
	None	Police Record									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	DUE TO Cerebral hemorrhage										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.	(b)	DUE TO	INTERVAL BETWEEN ONSET AND DEATH sudden								
	(c)		Fracture of skull								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
Fracture of left femur & hip. Comp. Fracture rt. leg											
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18) Struck by hit and run auto (pedestrian)										
20c. TIME OF INJURY Hour XX m 7:05 p.m.	Month, Day, Year 6.11/58	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Bethesda	(County) Montg.	(State) Md.					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <i>Frank J. Broschart</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>								DATE SIGNED 6/11/58		
EXAMINER'S NAME (Type) Frank J. Broschart	22c. NAME OF CEMETERY OR CREMATORIUM Parklawn Cemetery								22d. LOCATION (City, town, or county) Montgomery County, Md.		
22a. BURIAL, CREMATION REMOVAL (Specify) Burial	22b. DATE THEREOF 6-14-58	22e. ADDRESS Bethesda, Md.								24a. REC'D BY REGISTRAR ROBERT A. PUMPHREY	24b. REGISTRAR'S SIGNATURE <i>C. Pumphrey</i>
23. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY	24c. DATE JUN 16 '58										
VS A15ME SM 2 '37											



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 Item 9 File #231 7-23-58 et
CERTIFICATE OF DEATH

07060

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) b. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		c. LENGTH OF STAY IN 1b 2 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INST TUT ON Montgomery County General		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Laytonsville	
f. STREET ADDRESS		g. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Harry	Middle Samuel	Last Riggs
4. DATE OF DEATH	Month June	Day 16	Year 19 58
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 5, 1880
9. AGE (in years last birthday) 77 98 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer	11. KIND OF BUSINESS OR INDUSTRY	12. BIRTHPLACE (State or foreign country) Maryland
13. CITIZEN OF WHAT COUNTRY? USA	14. FATHER'S NAME Harry Riggs	15. MOTHER'S MAIDEN NAME Louise Wood	16. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No
17. SOCIAL SECURITY NO. Unk nown	18. INFORMANT Mrs. H. Samuel Riggs -Rt. #1 Gaithersburg	Address Md.	19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis		INTERVAL BETWEEN ONSET AND DEATH 48 hours	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) Arteriosclerosis, Generalized		Many years	
DUE TO (c)			
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Rheum-toid Arthritis, Severe:			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20e. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3/20 , 1955, to 6/16 , 1958, that I last saw the deceased alive on 6/16/ 19 58 , and that death occurred at 11:04A , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>G. F. Meadows, M.D.</i>		ADDRESS (Street, city or town, state) Damascus, Maryland DATE SIGNED 6/17/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 18, 1958	
22c. NAME OF CEMETERY OR CREMATORIUM Goshen Cemetery		22d. LOCATION (City, town, or county) Goshen, Maryland (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Troy W. Barber Laytonsville, Md.</i>		24a. REC'D BY REGISTRAR DATE JUN 19 1958	
ADDRESS		24b. REGISTRAR'S SIGNATURE <i>DeLoach</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7072

CERTIFICATE OF DEATH

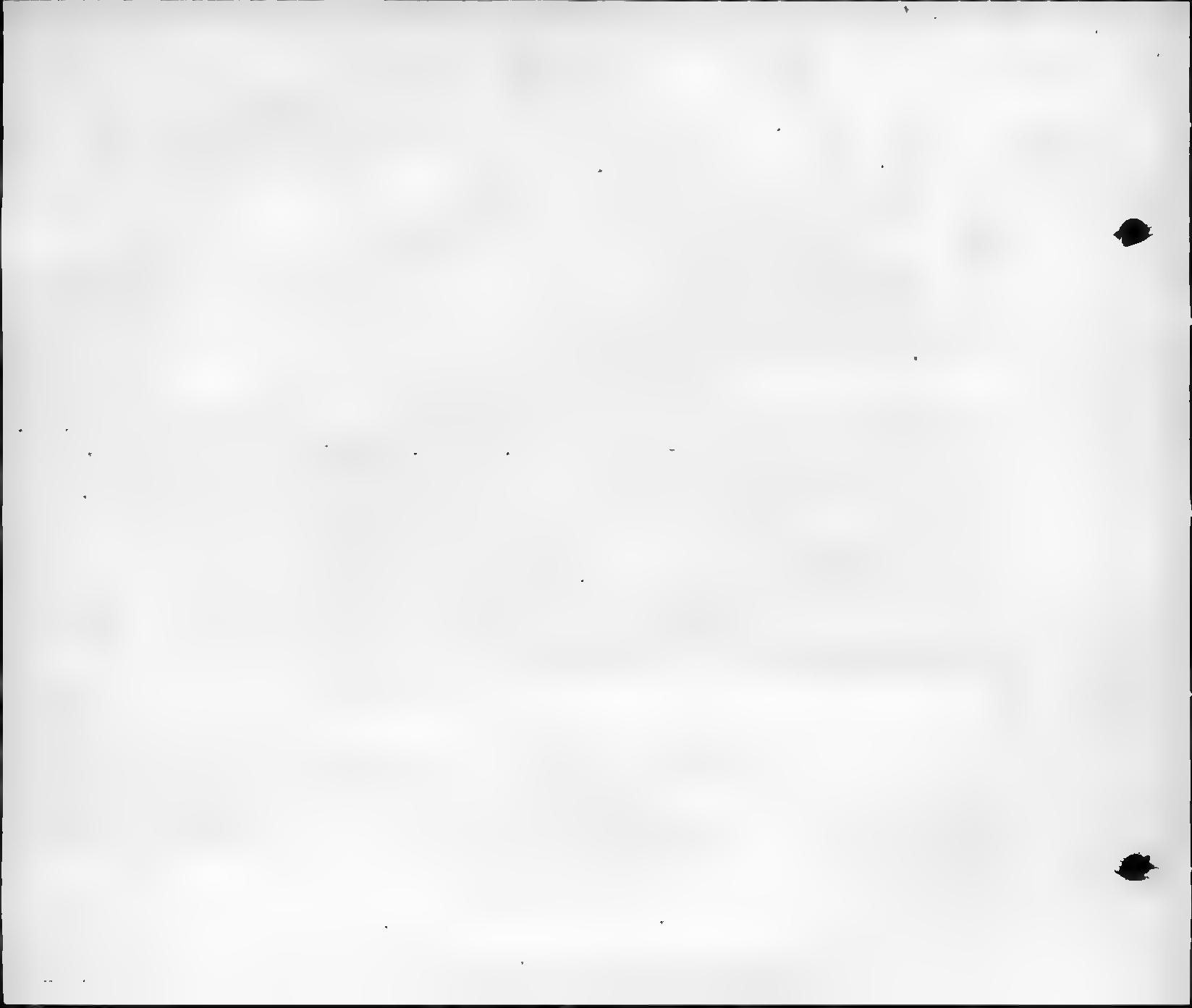
Reg. Dist. No.

07061

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 508 Gilmoure Drive		e. STREET ADDRESS 508 Gilmoure Drive	
3. NAME OF DECEASED (Type or print) Edwin Rolla		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
4. DATE OF DEATH Month June 14 Day Year 19 58			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 12/18/67
9. AGE (In years last birthday) 90 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tour Dir. for Foreign Countries-own business		10b. KIND OF BUSINESS OR INDUSTRY Lime Springs, Iowa	
10c. CITIZEN OF WHAT COUNTRY USA			
13. FATHER'S NAME William Rochester		14. MOTHER'S MAIDEN NAME Annette	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO 579-24-7247A	
17. INFORMANT Mrs. Edna B. Rochester, 508 Gilmoure Dr.		Address Silver Spring, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH 3 days	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO Chronic myocarditis = Undetermined (c) DUE TO Cardiac failure Undetermined (d) Generalized Arteriosclerosis Undetermined			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Sensitivity		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. — 19 p. m. —		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov. 12, 1957 to June 14, 1958, that I last saw the deceased alive on June 13, 1958, and that death occurred at 10:13 AM, from the causes and on the date stated above			
ACTUAL SIGNATURE George L Ball		ADDRESS (Street, city or town, state) 7835 Eastern Ave, Silver Spring, Md.	
PHYSICIAN'S NAME (Type) George L Ball		DATE SIGNED June 14, 1958	
22a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION		22b. DATE THEREOF 6/17/58	
22c. NAME OF CEMETERY OR CREMATORIAL FT. LINCOLN CEMETORY		22d. LOCATION (City, town, or county) PRINCE GEORGE COUNTY	
23. FUNERAL DIRECTOR'S SIGNATURE Charles E. Purkiss		24a. REC'D BY REGISTRAR VS AIS (4) ISM 10/57	
ADDRESS SILVER SPRING, MD.		24b. REGISTRAR'S SIGNATURE John Smith	
DATE JUN 17 '58			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7073

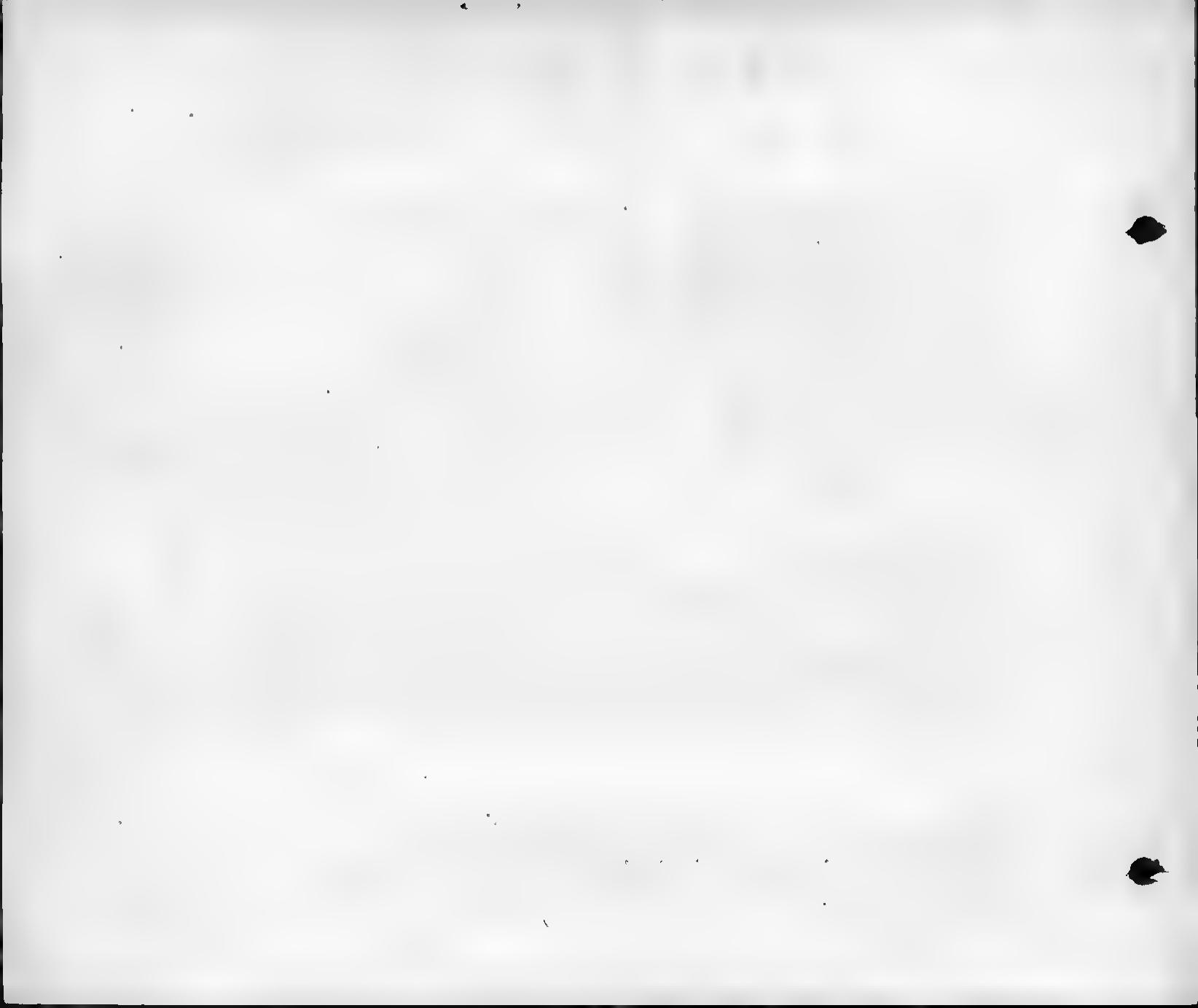
CERTIFICATE OF DEATH

08193
Reg. Dist. No. 215

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 2 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 2 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland		b. COUNTY St. Mary's		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN lb 1 day		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lexington Park		d. STREET ADDRESS 503 Ranger Road		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Margaret		First	Middle	last ROCK	4. DATE OF DEATH June 29 1958	Month	Day	Year
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		B. DATE OF BIRTH 6-28-58	9 AGE (In years last birthday) yrs 31	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS Days 0	Hours 0
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11 BIRTHPLACE (State or foreign country) Maryland		12 CITIZEN OF WHAT COUNTRY U.S.		
13. FATHER'S NAME Robert Ronald ROCK			14. MOTHER'S MAIDEN NAME Margaret Ann MELODY					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO None		17. INFORMANT Father, Robert R. ROCK (Same As #2)		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Anoxia 16.2.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. } (b) Fetal Allectasis DUE TO (c) Prematurity PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) } INTERVAL BETWEEN ONSET AND DEATH 31 hrs 16 min.								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from 28 June 1958 , to 29 June 1958 , that I last saw the deceased alive on 29 June 1958 , and that death occurred at 12:25A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL <i>Adam T. Thorp Jr.</i> M.D. U.S. Naval Hospital, Bethesda, Md. 6-30-58								
PHYSICIAN'S NAME (Type) Adam T. Thorp, Jr. LT, MD, USN U.S. Naval Hospital, Bethesda, Md.								
22a. BURIAL, CREMATION OR REMOVAL (Specify) Burial		22b. DATE THEREOF 3 July 1958		22c. NAME OF CEMETERY OR CREMATORIUM Holy Face Cemetery		22d. LOCATION (City, town, or county) (State) Great Mills, Maryland		
23. FUNERAL DIRECTOR'S SIGNATURE W. C. Mattingley, Leonardtown, Md.		ADDRESS 2051 222 XV /		24a. REC'D BY REGISTRAR JUL 9 '58		24b. REGISTRAR'S SIGNATURE Albert J. Edeken		



1 07062

**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any detail is necessary, please execute certificate, writing the word "Pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Farm P.M.J. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-travel permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15ME
SM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7074 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution, residence before admission)		Reg. Dist. No.	
Montgomery				a. STATE Maryland		b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
Bethesda		1 day		Rockville			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS		103 Dawson Avenue		IS REDDITE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Suburban Hospital							
3. NAME OF DECEASED (Type or print)		First	Middle	4. DATE OF DEATH		Month Day Year	
Mary		F	Rogers	6 27 58			
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH		9. AGE (In years from birthday) 65 yrs	
Female		White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	12/20/92			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		IF UNDER 1 YEAR IF UNDER 24 HRS	
At Home		Homemaker		Virginia		Months Days Hours Min	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		Jackson		12. CITIZEN OF WHAT COUNTRY?	
Tiv B sker		?				U.S.A.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address	
No		None		Emmett Rogers - Husband			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) INTRAPORTAL HEMORRHAGE							
DUE TO 825X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last							
(b) CEREBRAL ITALIA							
DUE TO							
(c) AUTOMOBILE ACCIDENT							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.							
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month, Day, Year Hour 7:30 A.M.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Name, Room No., factory, street, or Ident.) Rockville Montg. Md. (State)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
6/26/58				Rockville			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>Frank J. Broschart</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 6/28/58			
EXAMINER'S NAME (Type)							
22a. BURIAL, CREMATION REMOVAL (Specify) Burial		22b. DATE THEREOF 7-1-58		22c. NAME OF CEMETERY OR CREMATORIUM Parklawn Cemetery		22d. LOCATION (City, town, or county) Montgomery Co., Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. MURPHY		ADDRESS Bethesda, Md.		24a. REG'D BY REGISTRAR JUN 30 1958		24b. REGISTRAR'S SIGNATURE <i>W. Clegg</i>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7075

CERTIFICATE OF DEATH

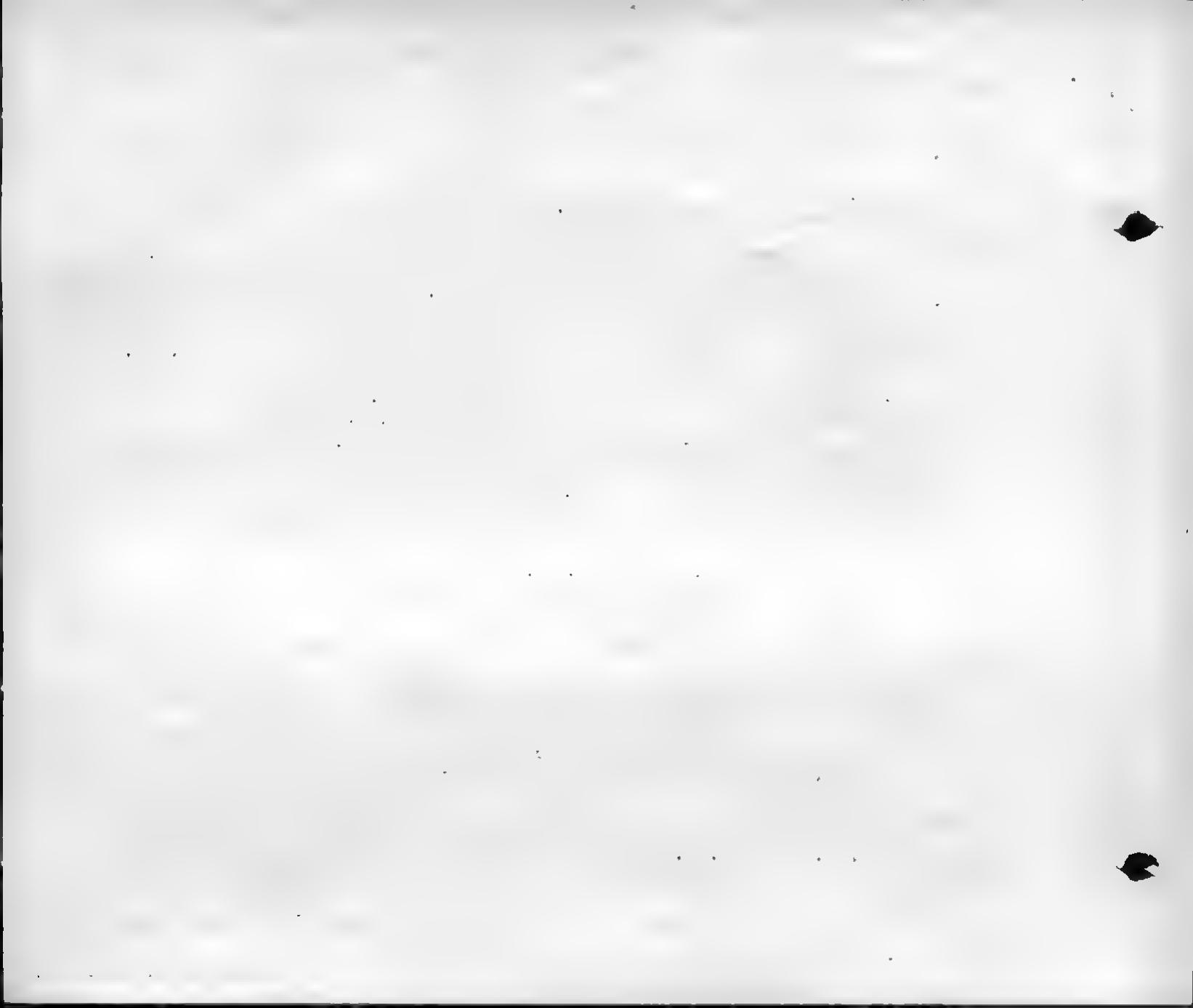
Reg. Dist. No.

07063

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Florida	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		b. COUNTY	
c. LENGTH OF STAY IN 1b 227 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Jacksonville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		d. STREET ADDRESS 4832 Highway Avenue	
3. NAME OF DECEASED (Type or print) Thomas		First Thomas	Middle Bernie
4. DATE OF DEATH June 2, 1958		5. SEX Male	6. COLOR OR RACE White
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH December 10, 1898	
8. DATE OF BIRTH December 10, 1898		9. AGE (In years last birthday) 59 yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Building	
11. BIRTHPLACE (State or foreign country) Florida		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Thomas E. Rucker		14. MOTHER'S MAIDEN NAME Minnie L. Bennett	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 265-24-3780	
17. INFORMANT The Medical Record		Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Renal failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) Cystopyelitis (c) Adrenal Carcinoma with widespread metastasis			
INTERVAL BETWEEN ONSET AND DEATH ~1 month ? (chrc. inc) >1 year			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Tripharyngitis			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from October 18, 1957 , to June 2, 1958 , that I last saw the deceased alive on June 2, 1958 , and that death occurred at 7:40 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center National Institutes of Health Bethesda 14, Maryland			
ACTUAL SIGNATURE S. M. Kahn		DATE SIGNED 6/3/58	
PHYSICIAN'S NAME (Type) S. M. Kahn, M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Bur-Transit		22b. DATE THEREOF 6/4/58	
22c. NAME OF CEMETERY OR CREMATORY Edgewood Cemetery		22d. LOCATION (City, town, or county) (State) Jacksonville, Florida	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		ADDRESS Bethesda, Maryland	24a. REC'D BY REGISTRAR JUN 6 1958
		24b. REGISTRAR'S SIGNATURE L. J. Smith	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician and completely filled in by the funeral director.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07064

7076

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE Maryland		b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		c. LENGTH OF STAY IN 1b 1 mo.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring, Md.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery County General		d. STREET ADDRESS RT. #1 Box 221		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First John	Middle J. Ryan	Last 	4. DATE OF DEATH June 6 1958	Month June	Day 6	Year 1958
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH Nov. 7, 1893	9. AGE (In years last birthday) 64 yr.	IF UNDER 1 YEAR Months 	IF UNDER 24 HRS Days 	Address Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) farmer		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or Foreign country) Conn.		12. CITIZEN OF WHAT COUNTRY United States	
13. FATHER'S NAME John Thomas Ryan		14. MOTHER'S MAIDEN NAME Margaret Carroll					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unknown		16. SOCIAL SECURITY NO.		17. INFORMANT To D. Ryan (wife) same as above		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a)		DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)		Toxemia Peritonitis Carcinoma of Stomach		INTERVAL BETWEEN ONSET AND DEATH 1 wk. 1 wk. 1 yr.	
DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour e.g. p.m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) ADDRESS (Street, city or town, state)	(County)	(State)	
21. I certify that I attended the deceased from May 6 , 1958, to June 6 , 1958, that I last saw the deceased alive on June 6 , 1958, and that death occurred at 5:25 P.M. from the causes and on the date stated above						DATE SIGNED 6/6/58	
ACTUAL SIGNATURE Richard A. Yates	PHYSICIAN'S NAME (Type) Dr. Richard A. Yates	M.D.	Olney, Md.				
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 6/10/1958	22c. NAME OF CEMETERY OR CREMATORIUM ARLINGTON NATIONAL CEMETERY ARLINGTON, VIRGINIA	22d. LOCATION (City, town, or county) (State)				
23. FUNERAL DIRECTOR'S SIGNATURE MARTIN W. HYSONG COMPANY INC.		ADDRESS 1300 N. STREET, N.W.	24a. REC'D BY REGISTRAR DATE JUN 9 '58	24b. REGISTRAR'S SIGNATURE Alfred E. ...			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

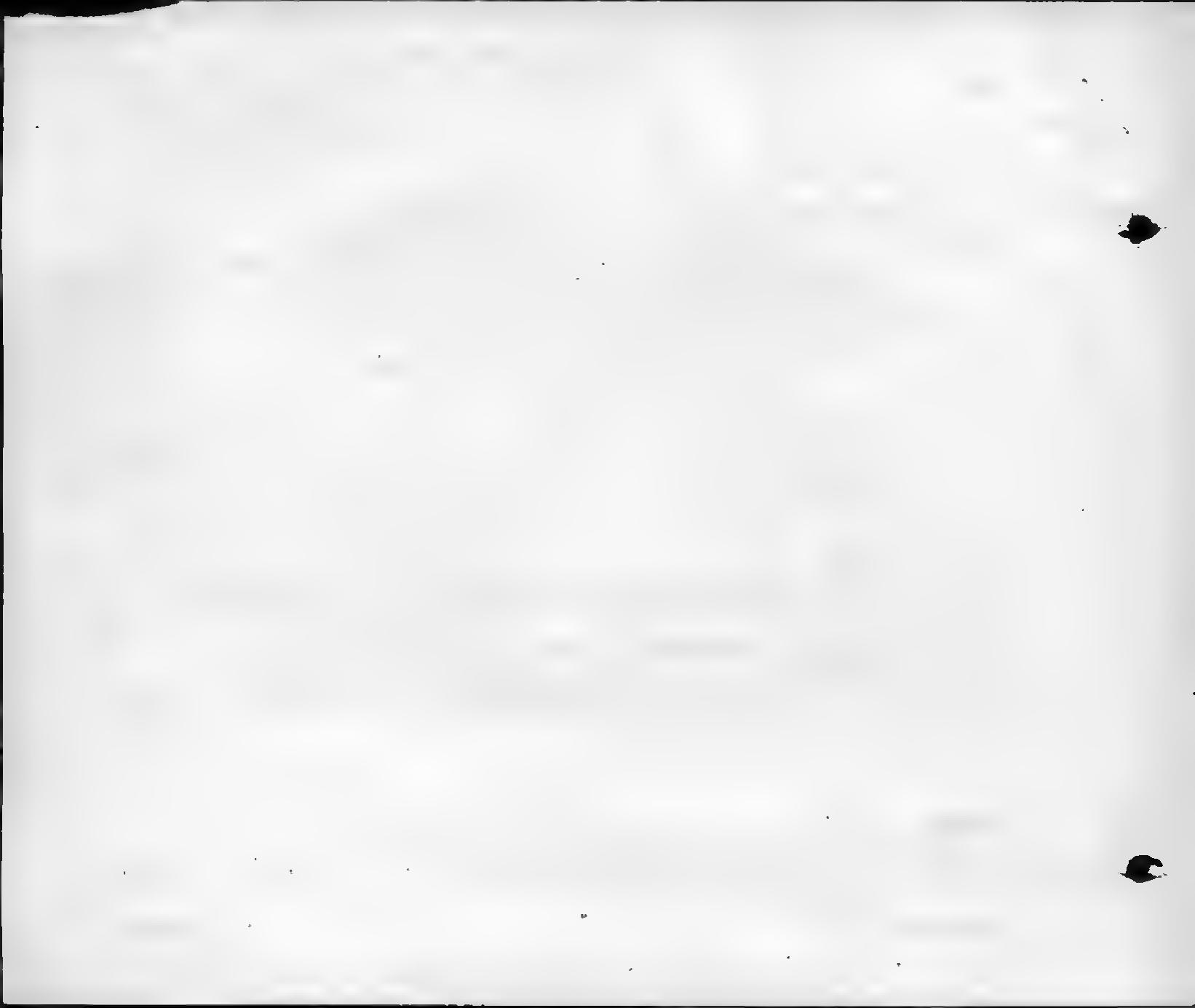
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

924-2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial transit permit; then, please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										07065			
7077 CERTIFICATE OF DEATH										Reg. Dist. No.			
1. PLACE OF DEATH a. COUNTY Montgomery					2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland					b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Seneca								
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital					d. STREET ADDRESS RFD - 213 Monroe st					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First Isabelle	Middle D.	Last SAGER	4. DATE OF DEATH		Month June	Day 30	Year 19 58				
5. SEX		6. COLOR OR RACE Female White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 28 1909		9. AGE (In years last birthday) 48 yrs	10. IF UNDER 1 YEAR 7 Months	11. IF UNDER 24 HRS 2 Days				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY Industry		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY US							
13. FATHER'S NAME Lorenzo Sager		14. MOTHER'S MAIDEN NAME Jessie Kirby		15. ADDRESS Strong's Garage Bldg., Rockville Md.									
16. SOCIAL SECURITY NO Unknown										17. INFORMANT			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Hepatic coma										INTERVAL BETWEEN ONSET AND DEATH 4 days			
10. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Bleeding esophageal varices (c) Portal cirrhosis										4 days unknown			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>													
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month. Day. Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from _____, 19_____, to _____, 19_____, that I last saw the deceased alive on _____, 19_____, and that death occurred at _____, M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Jason Geiger										DATE SIGNED			
ACTUAL SIGNATURE Jason Geiger										M.D.			
PHYSICIAN'S NAME (Type) JASON GEIGER										931 Pershing Drive, Silver Spring, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/3/58		22c. NAME OF CEMETERY OR CREMATORIUM Darnestown		22d. LOCATION (City, town, or county) Darnestown		(State) Maryland					
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Maryland										24a. REC'D BY REGISTRAR DATE JUL 7 1958		24b. REGISTRAR'S SIGNATURE John Smith	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

X
7078

CERTIFICATE OF DEATH

Reg. Dist. No. 07066

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND			2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. LENGTH OF STAY IN lb 10 BELMONT COURT		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 10 BELMONT COURT		d. STREET ADDRESS 10 BELMONT COURT		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First AUBREY	Middle R.	Last SAMPSELLE	4. DATE OF DEATH JUN	Month Day Year 10 19 58
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/9/93	9. AGE (In years lost birthday) 64 yrs	10. IF UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during part of working life, even if retired) Chiefly Office Work Dining Car Dept.			10b. KIND OF BUSINESS OR INDUSTRY B. & O. Railroad	11. BIRTHPLACE (State or foreign country) Pennsylvania	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME HENRY SAMPSELLE			14. MOTHER'S MAIDEN NAME LYDIA ROSS		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? <small>If yes, give war or date of service:</small> No		16. SOCIAL SECURITY NO. NONE		17. INFORMANT Mrs. Anna M. Sampselle, 10 Belmont Court Address Silver Spring, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Cerebral emboli Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO Generalized cerebralclerosis (c) DUE TO Myocardial ischemia			INTERVAL BETWEEN ONSET AND DEATH 3 minutes 5 years.		
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	Day	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 10-6, 1950, to 6-10, 1958, that I last saw the deceased alive on 6-10, 1958, and that death occurred at 10:15 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <i>W.B. Wardrop MD</i> M.D. <i>837 Bonifant St. Silver Spring, Md.</i>					
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 6/13/58		22c. NAME OF CEMETERY OR CREMATORIUM CEDAR HILL CEMETERY	22d. LOCATION (City, town, or county) (State) PRINCE GEORGE COUNTY, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Werner G. Humphrey, SILVER SPRING, MD.</i>			ADDRESS	24a. REC'D BY REGISTRAR DATE JUN 13 '58	24b. REGISTRAR'S SIGNATURE <i>Alv. reaver</i>



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
707 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07067

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute a certificate, writing the word "Pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Post 4 sheets (or forwarded to the Chief Medical Examiner's Office along with Form PH3). Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE Where deceased lived. If institution Residence before adm is an	
Montgomery Great Falls		MARYLAND a. STATE b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN TB d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
Petoniac R.		Arlington Arlington	
e. STREET ADDRESS 3821 Larson St		e. S RESID ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
f. FIRST MIDDLE LAST NAME Edward Miles Sargent		4. DATE OF DEATH June 3 1958	
g. COLOR OR RACE Male white		5. SEX MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> b. DATE OF BIRTH 8-19-1910	
h. W.DOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. AGE (In years) 47 yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY govt.	
11. BIRTHPLACE (State or foreign country) Iowa		12. CITIZEN OF WHAT COUNTRY? n.s.a.	
13. FATHER'S NAME Frank Sargent		14. MOTHER'S MAIDEN NAME Margaret n ^t Donaldson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 17. INFORMANT Wm Sargent - Same as dec	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 929.8 DUE TO Cerebral edema Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO drowning (c)		Address INTERVAL BETWEEN ONSET AND DEATH Found dead in Bateman R.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Unknown - Had been missing since 6-3-58	
20c. TIME OF INJURY Month, Day, Year Hour a. m. ? 1958 p. m. ?		20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) at work <input type="checkbox"/> Not at work <input checked="" type="checkbox"/> Petoniac R Great Falls Montgomery Md (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE FRANK J. BROSCHEIT		DATE SIGNED 6-3-58	
EXAMINER'S NAME (Type) FRANK J. BROSCHEIT		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION OR REMOVAL (Specify) Burial		22b. DATE THEREOF 6/5/58	
22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Columbia Gardens Bethesda, Md.		22d. LOCATION (City, town, or county) Arlington, Va. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		24a. REC'D BY REGISTRAR DATE JUN 6 '58	
		24b. REGISTRAR'S SIGNATURE John E. Edwards	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 2-2m 120 5-12-68 et

07068

7080

CERTIFICATE OF DEATH

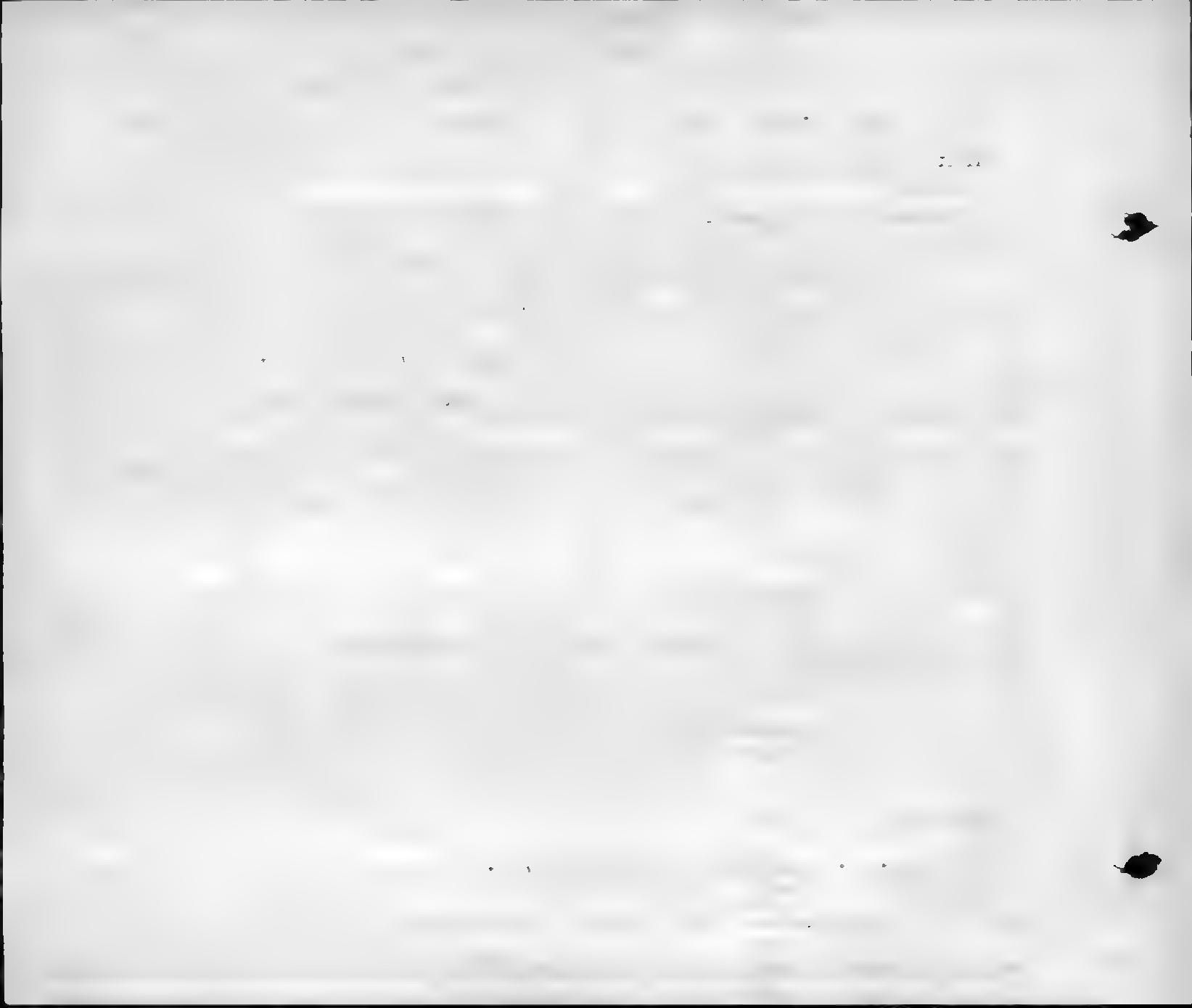
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery Co. Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gaithersburg Olney		c. LENGTH OF STAY IN lb 420½ hours	
d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OR INSTITUTION Montgomery County Gen. Hospital		e. STREET ADDRESS Emory Grove Road	
3. NAME OF DECEASED (Type or print)	First THOMAS	Middle	Last SELLMAN
4. DATE OF DEATH	Month 6	Day 1	Year 1958
5. SEX Male	6. COLOR OR RACE C	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-25-92
9. AGE (in years last birthday) 65 1/2 yrs	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) invalid	11. KIND OF BUSINESS OR INDUSTRY Maryland, Mont. Co.	12. CITIZEN OF WHAT COUNTRY? United States
13. FATHER'S NAME Henry Sellman	14. MOTHER'S MAIDEN NAME Ella Fitzburgh	Address	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unknown	16. SOCIAL SECURITY NO.	17. INFORMANT	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Asphyxiation, thrombocytopenia</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			INTERVAL BETWEEN ONSET AND DEATH 2 wks
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)		
20c. TIME OF INJURY Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from May 1958 to June 1958 that I last saw the deceased alive on June 1 1958 , and that death occurred at Sandy Spring , M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) Sandy Spring Md. DATE SIGNED 4/3/58			
ACTUAL SIGNATURE <i>A. D. Bonifant</i>	M.D.		
PHYSICIAN'S NAME (Type) A. D. Bonifant	Sandy Spring Md.		
22a. BURIAL, CREMATION, REMOVAL (Specify) Funeral	22b. DATE THEREOF 6-3-58	22c. NAME OF CEMETERY OR CREMATORIUM Church Cemetery	22d. LOCATION (City, town, or county) EMORY GROVE (State) Md
23. FUNERAL DIRECTOR'S SIGNATURE R L. Snowden	ADDRESS Rockville, Md.	24a. REC'D BY REGISTRAR DATE JUN 5 '58	24b. REGISTRAR'S SIGNATURE W. E. L.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7081

CERTIFICATE OF DEATH

07070

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b Suburban		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		d. STREET ADDRESS 4937 Cordell Avenue	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Shackelford,				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	Last XX	Middle E.	First Sophie	4. DATE OF DEATH	Month June	Day 27	Year 19 58
5. SEX Female	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 2/7/69	9. AGE (In years last birthday) 89 yrs.	10. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	11. IF UNDER 24 HRS Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Va.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Ruben Harlow				14. MOTHER'S MAIDEN NAME Elizabeth Gillispie			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO No		17. INFORMANT Myrtle E Donaldson- Item#2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Toxemias DUE TO Subdiaphragmatic & Retroperitoneal Abscess INTERVAL BETWEEN ONSET AND DEATH 4 days Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) Biliary Obstruction with Secondary Colangitis DUE TO 7 days (c) unknown							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 104 Cherry Chase Dr.		(County) Prince George Co. (State) Md.	
21. I certify that I attended the deceased from June 21, 1958 to June 21, 1958 , that I last saw the deceased alive on June 21, 1958 , and that death occurred at 2:30 P.M. from the causes and on the date stated above. ACTUAL SIGNATURE George A. Gray Jr. ADDRESS (Street, city or town, state) Cherry Chase 15, Md. DATE SIGNED 6/21/58							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/30/58		22c. NAME OF CEMETERY OR CREMATORIUM Ft. Lincoln		22d. LOCATION (City, town, or county) Prince George Co., Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE R.D. Humphrey Funeral Home		ADDRESS Bethesda, Md.		24a. REC'D BY REGISTRAR John Smith		24b. REGISTRAR'S SIGNATURE John Smith	
DATE JUN 30 '58				DATE JUN 30 '58			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please ~~remove~~ carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



07071

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute a certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the medical director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be given as a brief-of-transit ~~as~~ or removal, and in my event within 72 hours after death or its designated agent, prior to burial, cremation, or removal, and in my event within 72 hours after death

1. PLACE OF DEATH
a. COUNTY

Montgomery

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Rockville

c. LENGTH OF STAY IN lb

3 days

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

1011 Rockcrest Dr

3. NAME OF
DECEASED
(Type or print)

Arthur Thomas Sheehan

First

Middle

Last

4. SEX

Male

5. COLOR OR RACE

white

6. MARRIED NEVER MARRIED

7. WIDOWED DIVORCED

8. DATE OF BIRTH

7-27-03

9. AGE (Years
and Months)

54

yrs

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Chef

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

DC

12 CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Thomas Sheehan

14. MOTHER'S MAIDEN NAME

Rose Samantha

Address

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)

No Yes, give war or dates of service

16. SOCIAL SECURITY NO.

579-22-1163

17. INFORMANT

Thelma Sheehan (wife) Item #2

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY,
IMMEDIATE CAUSE (a)

DUE TO

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

(b)

DUE TO

(c)

Coronary occlusion

INTERVAL BETWEEN
ONSET AND DEATH
*Fred died
in bed*

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS
PRIMARY or CONTRIBUTING CAUSE OF DEATH.

20c. TIME OF INJURY
Month, Day, Year
Hour o. m.
p. m.

19

20d. INJURY OCCURRED
While
of work Not while
of work

20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry , and in my opinion death resulted from: Natural causes , Accident , Suicide , Homicide , Undetermined manner

ACTUAL
SIGNATURE

EXAMINER'S
NAME (Type)

22e. BURIAL CREMATION
REMOVAL (Specify)
Burial

22f. DATE THEREOF
6/4/58

23. FUNERAL DIRECTOR'S SIGNATURE

Robert A. Lumphrey Bethesda, Maryland

M.D. CHIEF MEDICAL EXAMINER

ASSISTANT MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

DATE SIGNED

6-1-58

22g. LOCATION (City, town, or county)

(State)

Washington, D. C.

24e. REC'D BY REGISTRAR 24f. REG STRA'S SIGNATURE

DATE JUN 4 '58 *Leibach*



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7082

CERTIFICATE OF DEATH

07072

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE 11527 GRANDVIEW AVE.		b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		d. STREET ADDRESS 11527 GRANDVIEW AVE.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION (Home)				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) DENNIS ANTHONY SHEEHAN, SR.		First	Middle	Last	4. DATE OF DEATH JUNE 28 1958	Month	Day	Year	
S SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAY 30, 1906	9. AGE (In years last birthday) 52 yrs	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	Hours	Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) INSURANCE AGENT		10b. KIND OF BUSINESS OR INDUSTRY INSURANCE		11. BIRTHPLACE (State or foreign country) WASHINGTON, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME JOHN JOSEPH SHEEHAN		14. MOTHER'S MAIDEN NAME AGNES SULLIVAN		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		Address			
16. SOCIAL SECURITY NO 578-05-0398		17. INFORMANT CATHERINE M. SHEEHAN (WIFE)		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple Myeloma DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 8 MONTHS			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) NONE		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) NONE		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ 19 _____ p. m. _____		20d. INJURY OCCURRED White <input type="checkbox"/> Nat. white of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.) 11527 Grandview Ave.		20f. (City or town) Washington		(County) _____	(State) _____
21. I certify that I attended the deceased from June 28, 1958 , to June 28, 1958 , that I last saw the deceased alive on June 28, 1958 , and that death occurred at 3:30 P.M. , from the causes and on the date stated above. ACTUAL SIGNATURE R. Belden, M.D. ADDRESS (Street, city or town, state) 11527 Grandview Ave., Silver Spring, Md. DATE SIGNED June 28, 1958									
22a. BURIAL, CREMAT. ON, REMOVAL SPECIES Burial		22b. DATE THEREOF 7-2-58		22c. NAME OF CEMETERY OR CREMATORIUM Mt. Olivet Cemetery		22d. LOCATION (City, town, or county) Washington DC.		(State) _____	
23. FUNERAL DIRECTOR'S SIGNATURE Francis J. Collins		ADDRESS 3821-14th N.W. Wash. D.C.		24a. RECD. BY REGISTRAR DATE JUN 30 '58		24b. REGISTRAR'S SIGNATURE Alvarez			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7083

CERTIFICATE OF DEATH

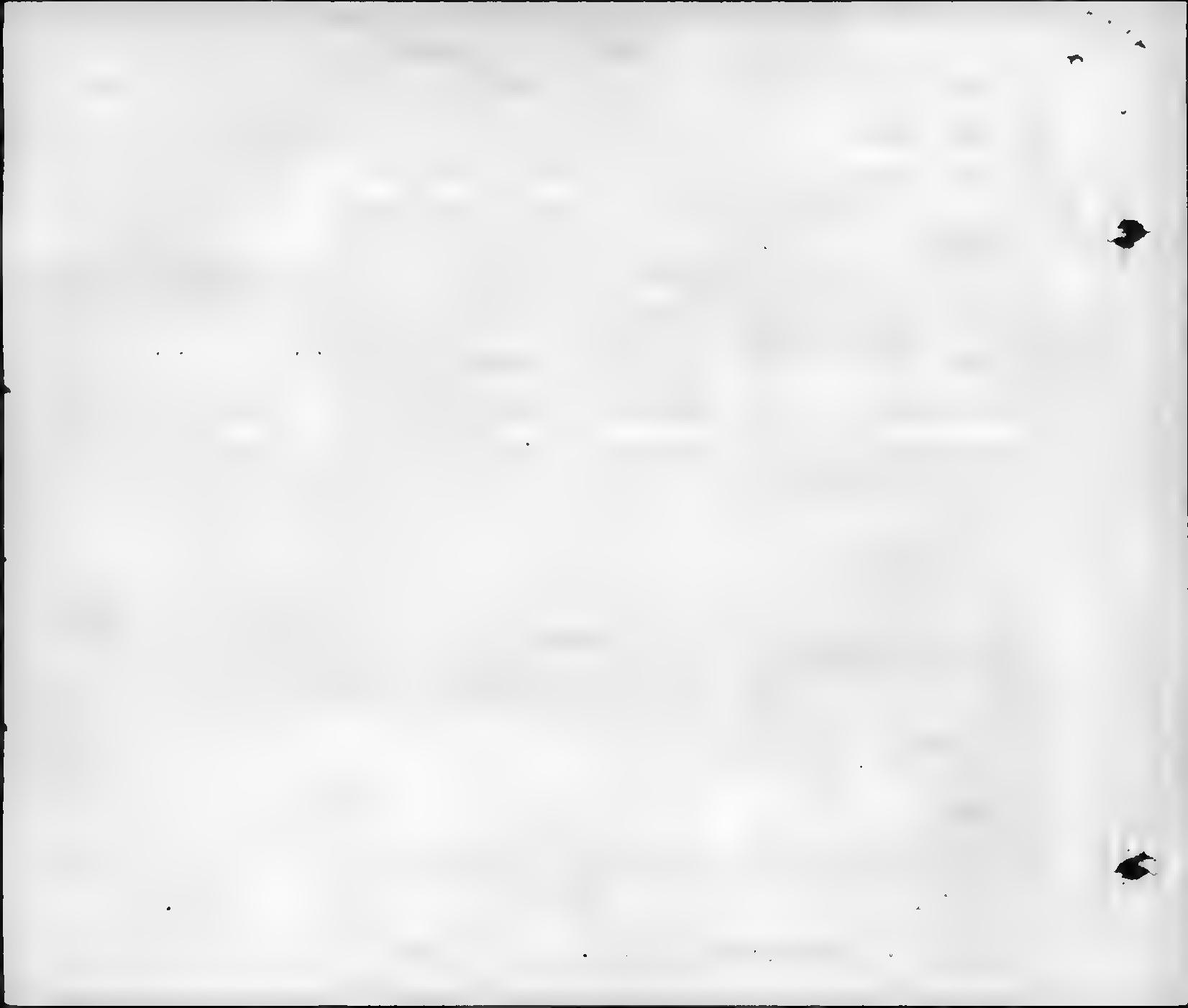
07073

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda	c. LENGTH OF STAY IN lb 3 hours	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woodacres	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital		d STREET ADDRESS 5903 Woodacres Drive	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print)	First Frank	Middle Davis	Last Shelley
4. DATE OF DEATH Month June Day 6 Year 1958			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 29, 1917
9. AGE (In years last birthday) 40 yr.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Public Relations	
10. KIND OF BUSINESS OR INDUSTRY Self-employed		11. BIRTHPLACE (State or foreign country) New York City, N.Y.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Frank Shelley	
14. MOTHER'S MAIDEN NAME Kathleen McSherry		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No	
16. SOCIAL SECURITY NO.		17. INFORMANT (wife) Mrs. Veronica Shelley	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 30IX Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO Hyper tension grade III (c)		INTERVAL BETWEEN ONSET AND DEATH 6 hours 2 yrs	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>7 a.m.</u> , 19 <u>56</u> , to <u>6 June</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>6 June</u> , 19 <u>58</u> , and that death occurred at <u>5 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE HERBERT MARTYN JR.		ADDRESS (Street, city or town, state) 5029 Bethesda Ave Bethesda Md 6 June 58 DATE SIGNED	
22a. BURIAL, CREMATION REMOVAL (Specify) Burial		22b. DATE THEREOF 6/10/958	
22c. NAME OF CEMETERY OR CREMATORIUM Gate of Heaven		22d. LOCATION (City, town, or county) Silver Spring, Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Md.		24a. REC'D BY REGISTRAR DATE 5/10 '58	
		24b. REGISTRAR'S SIGNATURE A. Pumphrey	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 17 FilmG231 7-21-58 et

07074

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		11. 2 USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <i>D.C.</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		b. COUNTY			
c. LENGTH OF STAY IN 1b <i>3 1/2 days</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Washington, D.C.</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Suburban Hospital</i>		d. STREET ADDRESS <i>5555 32nd ST. N.W.</i>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First <i>Norman</i>	Middle <i>Bishop</i>	Last <i>Sheppard</i>		
4. DATE OF DEATH	Month <i>June</i>	Day <i>2</i>	Year <i>1958</i>		
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Feb 17, 1895</i>		
9. AGE (In years lost birthday) <i>63 yrs.</i>	10. IF UNDER 1 YEAR Months <i>5</i>	11. IF UNDER 24 HRS. Days <i>1</i>	12. IF UNDER 24 HRS. Hours <i>0</i>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Legal Consultant</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>Veteran's Adm.</i>	11. BIRTHPLACE (State or foreign country) <i>Conn</i>	12. CITIZEN OF WHAT COUNTRY? <i>America</i>		
13. FATHER'S NAME <i>John Sheppard</i>	14. MOTHER'S MAIDEN NAME <i>Mary Davidson</i>	15. SNEPPARD Address <i>5555 32nd ST. N.W. Washington, DC</i>			
16. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>Yes</i>	17. SOCIAL SECURITY NO <i>1918 579-12-5353</i>	18. INFORMANT <i>Mrs. Norman J. Scully</i>	19. INTERVAL BETWEEN ONSET AND DEATH <i>1 yr.</i>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>1538</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO Carcinoma of colon (c)		20. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(b)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>1835 Eye St. N.W.</i>	20f. (City or town) <i>washington 6 D.C.</i>	(County)	(State)
21. I certify that I attended the deceased from <i>June 1956 to June 21, 1958</i> , that I last saw the deceased alive on <i>June 20, 1958</i> , and that death occurred at <i>M.</i> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED					
ACTUAL SIGNATURE <i>JAMES H. Scully</i>	M.D. <i>JAMES H. Scully</i>				
22a. BURIAL, CREMATION REMAINS burial	22b. DATE THEREOF <i>6/24/58</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Ft. Lincoln Cemetery</i>	22d. LOCATION (City, town, or county) <i>Pr. Geo. Co., Maryland</i>	(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>S. H. Kline CO -2901 14th St. N.W.,</i>	ADDRESS <i>Wash, D.C.</i>	24a. REC'D BY REGISTRAR <i>DAUN 23 '58</i>	24b. REGISTRAR'S SIGNATURE <i>Alv. Scully</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death Page 4

may be joined by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07075

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any document is necessary please execute it certificable, writing the word "Banding" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit Permit. File Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in accordance with 72 hours after death.

7085								Reg. Dist. No.			
1. PLACE OF DEATH		MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)						
a. COUNTY <i>Montgomery</i>		b. LENGTH OF STAY IN 1b <i>9 mo</i>			a. STATE <i>D.C.</i>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Kensington</i>		c. STREET ADDRESS <i>Washington 4409 Park St. N.E.</i>			b. COUNTY						
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Kensington Gardens Nursing Home</i>		d. DATE OF DEATH <i>Jan 28 1958</i>			e. 5 yrs. DISEASE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) <i>Elmer Wade Sheriff</i>		First Middle Last			Month Day Year						
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>11-12-1866</i>		9. AGE (In years at birthday) <i>91 yrs</i>		10. IF UNDER 1 YEAR Months Days Hours Min	
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>A. S. A.</i>					
13. FATHER'S NAME <i>Ceter Wood</i>		14. MOTHER'S MADDEN NAME <i>Maryast Skinner</i>									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address <i>Nursing Home Record</i>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>434.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH <i>15 min.</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)									
20c. TIME OF INJURY Hour a m p m		Month, Day, Year 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <i>Frank J. Broschart</i>		EXAMINER'S NAME (Type) <i>FRANK J. Broschart</i>		MD		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <i>6-28-58</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>July 1st 1958</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>Rock Creek</i>		22d. LOCATION (City, town, or county) <i>Washington D.C.</i>		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <i>Lee Funeral Home & Cremation Inc.</i>		ADDRESS <i>1001 14th Street N.E.</i>		24a. REC'D BY REGISTRAR DATE <i>JUL 1 '58</i>		24b. REGISTRAR'S SIGNATURE <i>Rebecca</i>					



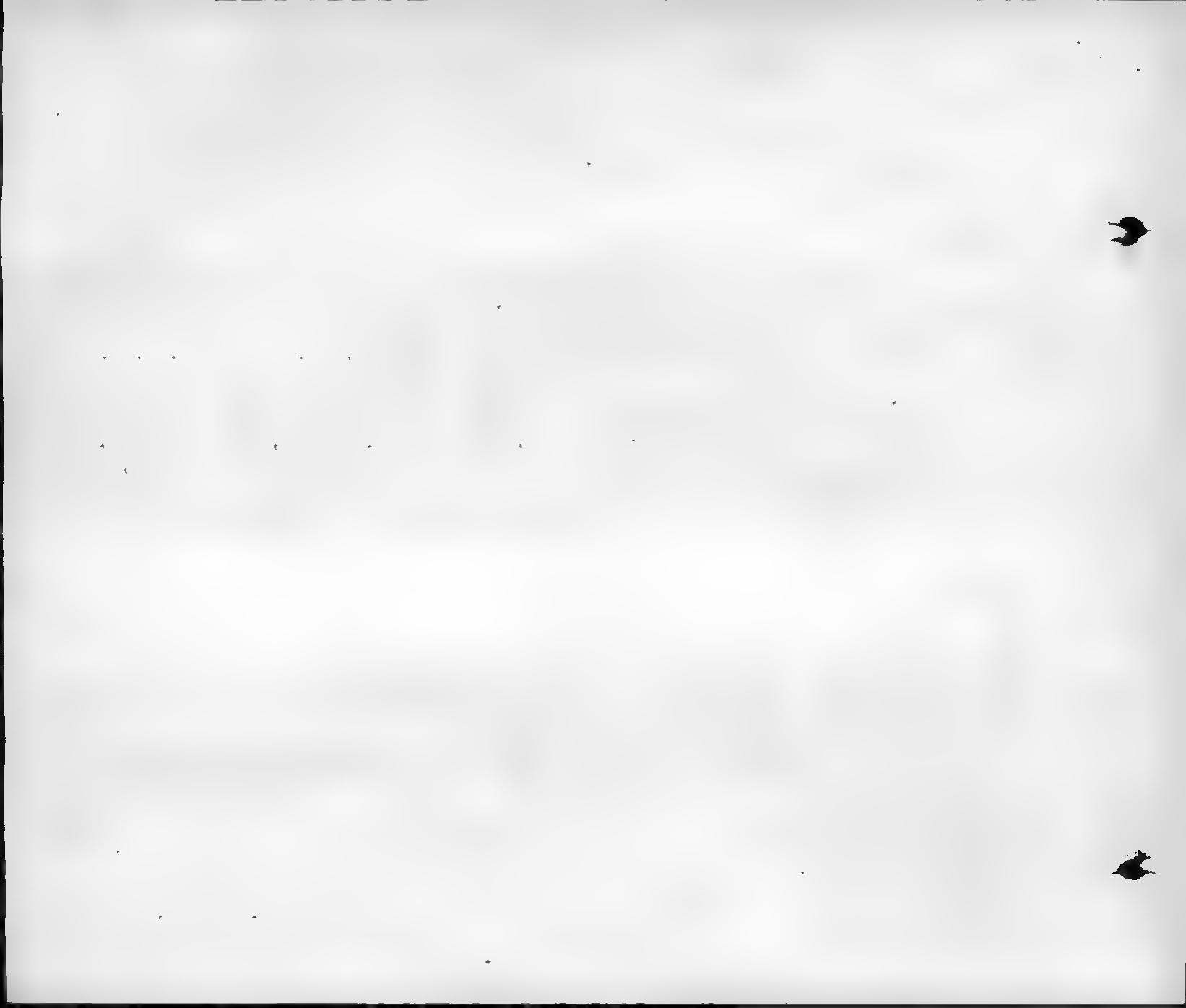
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
708 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07076

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any dec'd is necessary, please execute this certificate, writing the word "Pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 is to be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY MONTGOMERY		MARYLAND		Reg. Dist. No	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) KENSINGTON		c. LENGTH OF STAY IN 1b 1½ hrs.		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND b. COUNTY PRINCE GEORGE'S	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 3221 BLUFORD ROAD		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BLADENSBURG		IS PERSON ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) FRANKLIN WATERS SHREVE		d. STREET ADDRESS 4107 - 51st STREET		4. DATE OF DEATH JUNE 21	
5. SEX MALE COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH NOV. 20, 1904		9. AGE (In years last birthday) 53 yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALESMAN		10b. KIND OF BUSINESS OR INDUSTRY HOME FREEZER FOOD CO.		11. BIRTHPLACE (State or foreign country) DICKERSON, MD.	
13. FATHER'S NAME DANIEL T. SHREVE		14. MOTHER'S MAIDEN NAME EFFIE HAMMOND		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? NO		16. SOCIAL SECURITY NO 577-01-9558		17. INFORMANT Mrs. Genevieve C. Shreve, 4107 51st St.	
				Address Baldensburg, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY OCCLUSION 410.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause first. DUE TO (c)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERM NAMED DISEASE CONDITION GIVEN IN PART I(a)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 120 ^f (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <i>Frank J. Broschart</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED JUNE 22, 1958	
EXAMINER'S NAME (Type) FRANK J. BROSCHART		22c. NAME OF CEMETERY OR CREMATORIUM Cedar Hill Cemetery		22d. LOCATION (City, town, or county) Prince Geo. County, Maryland (State)	
22a. BURIAL, CREMATION REMOVAL (Specify) BURIAL		22b. DATE THEREOF 6/24/58		24c. REC'D BY REGISTRAR JUN 24 '58	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Warren G. Humphrey</i>		ADDRESS Silver Spring, Md.		24d. REGISTRAR'S SIGNATURE <i>A. J. Schuck</i>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
7087 CERTIFICATE OF DEATH

07077

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) b. STATE					
Montgomery Maryland		Maryland b. COUNTY					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)					
Bethesda		PARKwood - McLean, Virginia					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS					
SUBURBAN		4414 Brookfield DR					
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print)		First	Middle				
ARTHUR W. SMITH		Lost	4. DATE OF DEATH				
			Month June Day 19 Year 1950				
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. IF UNDER 1 YEAR Months 10 Days 24 Hours 0 Min.	11. IF UNDER 24 HRS
Male		White		7/25/74	80 yrs		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Steward - Retired				CHATHAM, ENGLAND		USA	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME					
WILLIAM SMITH		Ann					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (For all personnel) (If yes, give war or date of service)		16. SOCIAL SECURITY NO		17. INFORMANT		Address	
No		131-09-5770		Norman L. Smith		Kensington, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))						INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		DUE TO		Esophageal varices		hours	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b)		Bleeding Esophageal varices		Unknown	
		DUE TO		Cirrhosis of the liver		Years	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (d)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20c. TIME OF INJURY Month Day Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____, from the causes and on the date stated above						ADDRESS (Street, city or town, state)	
ACTUAL SIGNATURE						DATE SIGNED	
PHYSICIAN'S NAME (Type)							
Robert T. Thibodeau, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIUM		22d. LOCATION (City, town, or county) (State)	
Cremation		6/23/58		Cedar Hill Crematory		Suitland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
Robert A. Lumirey Bethesda, Maryland				JUN 23 '58		DeLain	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07069

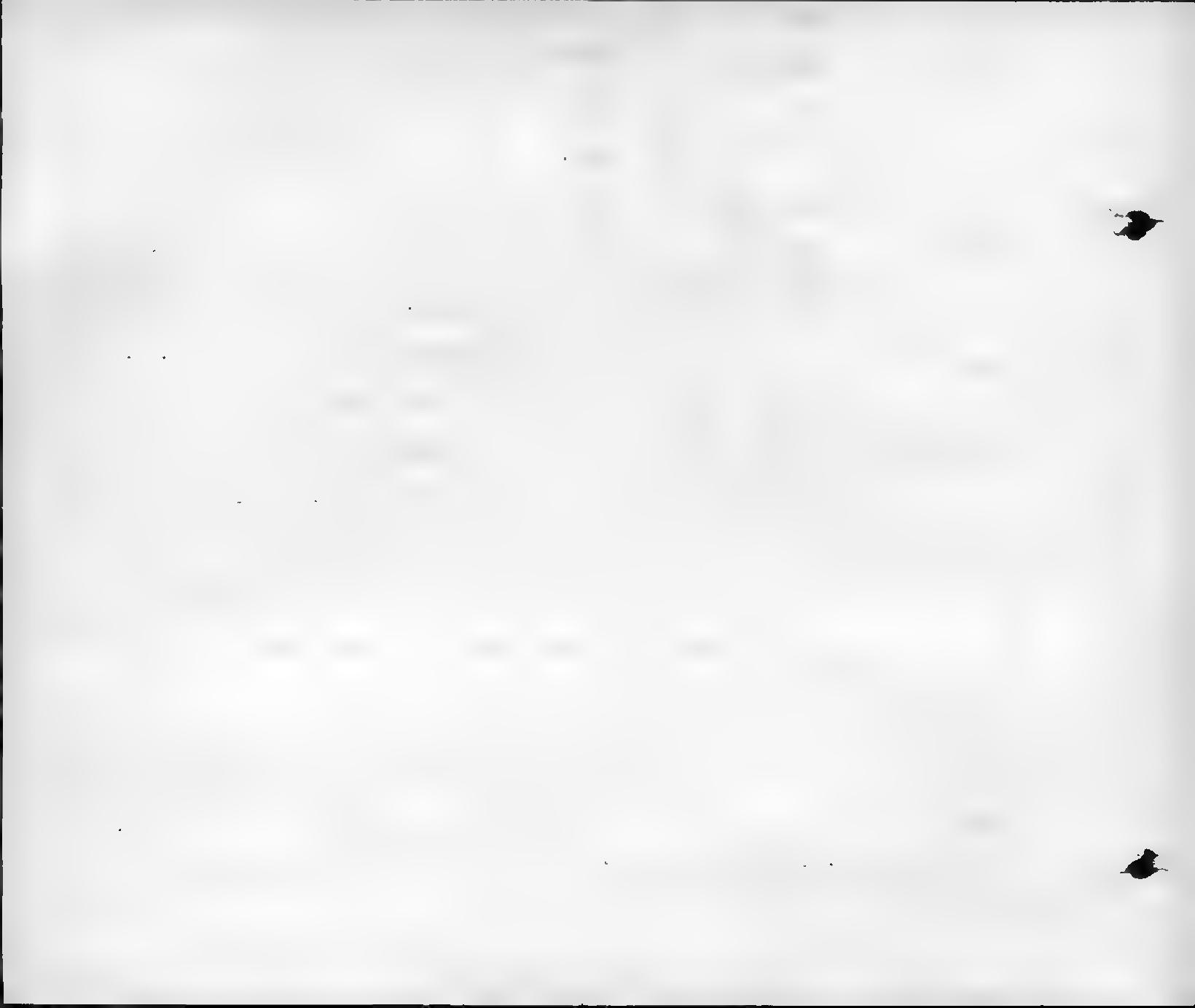
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland		b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		c. LENGTH OF STAY IN lb 1½ hrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Monrovia					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery County General Hospital		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First Baby	Middle Boy	Last Snapp	4. DATE OF DEATH June	Month 19	Day 19	Year 1958		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 19, 1958	9. AGE (In years last birthday) yrs 30	10. IF UNDER 1 YEAR Months 1	11. IF UNDER 24 HRS Days 1	Hours 1	Minutes 30	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Newborn			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) Maryland			
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME Patricia May Snapp			12. CITIZEN OF WHAT COUNTRY? U. S. A.			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.		17. INFORMANT mother		Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 116X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. b. DUE TO (c) unknown.									INTERVAL BETWEEN ONSET AND DEATH 5 months pregnancy 14 16 lbs or 14 slugs first about 1 1/2 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) none									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) 26 N Summit Ave.	(County) Baltimore, Md.	(State) Md.	
21. I certify that I attended the deceased from June 19, 1958 to June 19, 1958 , that I last saw the deceased alive on June 19, 1958 , and that death occurred at 9 PM , from the causes and on the date stated above. ACTUAL SIGNATURE W. A. Linthicum M.D. ADDRESS (Street, city or town, state) 26 N Summit Ave., Baltimore, Md.									DATE SIGNED 6-29-58
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-20-1958		22c. NAME OF CEMETERY OR CREMATORIUM Hanley Plot		22d. LOCATION (City, town, or county) Baltimore Co			
23. FUNERAL DIRECTOR'S SIGNATURE C. M. Watzl		ADDRESS Winfield, Md.		24a. REC'D BY REGISTRAR DATE JUN 23 '58			24b. REGISTRAR'S SIGNATURE Alfred E. ...		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death by the attending physician and completely filled in by the funeral director.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-death permit. Then please remove carbon paper. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

X

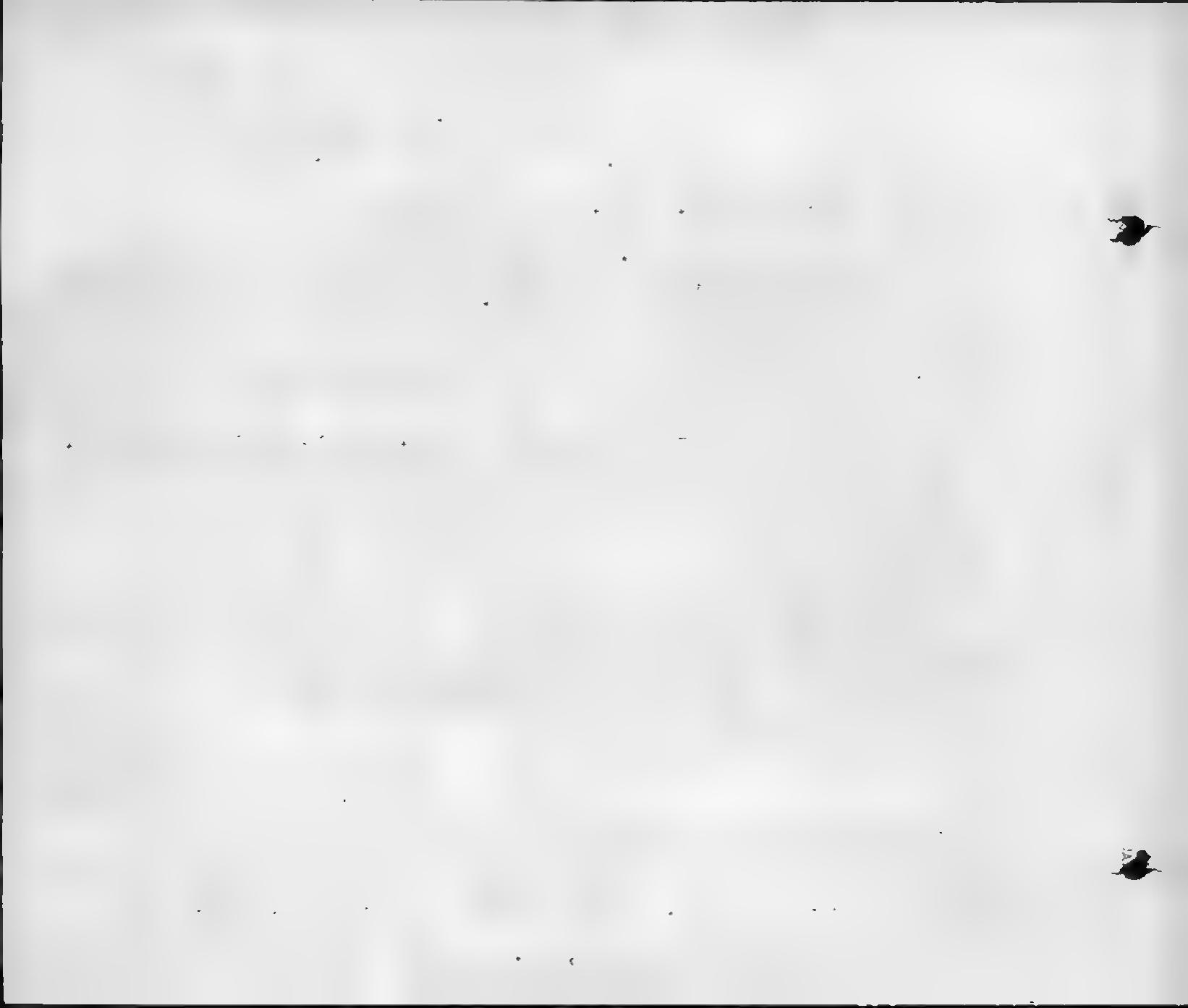
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7089 Item 7 F 1 M C 21 7-10-58 et
CERTIFICATE OF DEATH

07078

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. LENGTH OF STAY IN 1b 9 mos.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Havarest Home~571 Univ. Blvd.		e. STREET ADDRESS Kensington, Md.	
3. NAME OF DECEASED (Type or print) Mary		First S.	Middle Soper
4. DATE OF DEATH June 28 1958		Last Nov. 11, 1878	Month 79 yrs
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH Nov. 11, 1878		9. AGE (in years from birth date) 79 yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Franklin Duvall		14. MOTHER'S MAIDEN NAME Harriet Elizabeth Purdom	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -	
17. INFORMANT William F. Soper, Chevy Chase, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH 4 hours	
(b) Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		Myocardial Failure	
(c)		Diabetes mellitus; diabetic acidosis	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Generalized arteriosclerosis Severe			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Frederick, Maryland (County) Maryland (State)	
21. I certify that I attended the deceased from July 19, 1952 to June 28, 1958 , that I last saw the deceased alive on June 28, 1958 , and that death occurred at 11:57 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Thomas G. Hindman		ADDRESS (Street, city or town, state) 3935 Baltimore St., Kensington, Md.	
PHYSICIAN'S NAME (Type) Thomas G. Hindman		DATE SIGNED 6/29/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-1-58	
22c. NAME OF CEMETERY OR CREMATORIUM Mt. Olivet Cemetery		22d. LOCATION (City, town, or county) Frederick, Maryland (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Douglas Barber		ADDRESS Laytonsville, Md.	
24a. REC'D BY REGISTRAR 7 '58		24b. REGISTRAR'S SIGNATURE Albert Schuch	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

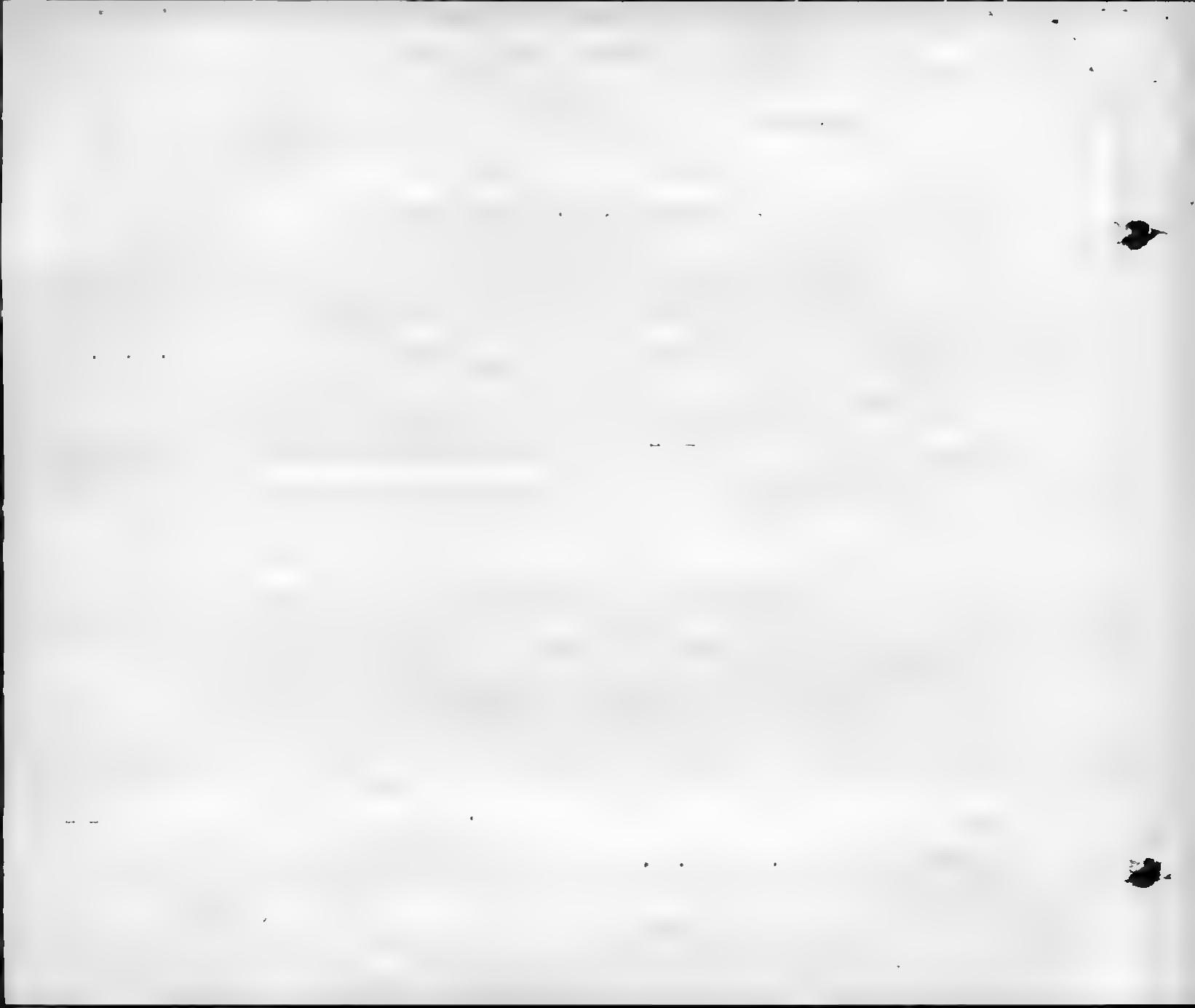
07079

7090

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Texas				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 47 days				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		e. STREET ADDRESS 309 Temple Avenue				
3. NAME OF DECEASED (Type or print) William Howard Spears		4. DATE OF DEATH June 1, 1958	Month Day Year			
S SEX Male	6 COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH December 18, 1923			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic		10b. KIND OF BUSINESS OR INDUSTRY Automotive				
10c. CITIZEN OF WHAT COUNTRY? U. S. A.		11. BIRTHPLACE (State or foreign country) Texas				
13. FATHER'S NAME Allan Spears		14. MOTHER'S MAIDEN NAME May Grizzell				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes WW II		16. SOCIAL SECURITY NO. 454-28-8030	17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) ACUTE LYMPHOCYTIC LEUKEMIA DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 3 1/2 mos.				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) URIC ACID NEPHROPATHY. CNS. LEUKEMIA.		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Lubbock	(County) Tarrant	(State) Texas
21. I certify that I attended the deceased from April 15, 1958 , to June 1, 1958 , that I last saw the deceased alive on June 1, 1958 , and that death occurred at 7:55 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 6-2-58						
ACTUAL SIGNATURE Richard K. Shaw		PHYSICIAN'S NAME (Type) Richard K. Shaw, M. D.		The Clinical Center National Institutes of Health Bethesda 14, Maryland		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial-transit		22b. DATE THEREOF 6/3/58		22c. NAME OF CEMETERY OR CREMATORIAL Lubbock		22d. LOCATION (City, town, or county) Lubbock, Texas
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		ADDRESS Bethesda, Maryland		24a. REC'D BY REGISTRAR John J. Smith		24b. REGISTRAR'S SIGNATURE John J. Smith
VS A15 (4) 15M 10/57				DATE June 1, 1958		



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7091

CERTIFICATE OF DEATH

07080

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <i>MARYLAND</i> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>	c. LENGTH OF STAY IN lb <i>D.C.A.</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Washington D.C.</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Suburban Hospital</i>	e. STREET ADDRESS <i>2122 Mass Ave NW</i>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Dr. Edward</i>	First <i>J.</i>	Middle <i>Stieglitz</i>	4. DATE OF DEATH <i>June 11 1958</i>		
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <i>JUNE 6, 1899</i>		
9. AGE (In years last birthday) <i>59 yrs.</i>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>MEDICAL DOCTOR</i>	11. KIND OF BUSINESS OR INDUSTRY <i>SELF-EMPLOYED</i>	12. BIRTHPLACE (State or foreign country) <i>Chicago Ill.</i>		
13. FATHER'S NAME <i>Julius Stieglitz</i>	14. MOTHER'S MAIDEN NAME <i>UNKNOWN</i>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Tell no. or unknown) <i>+</i>	16. SOCIAL SECURITY NO. <i>579-24-3146</i>	17. INFORMANT <i>Office Records</i>	Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>ACUTE PULMONARY EDEMA</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. <i>420.1</i> (b) <i>POSTERIOR MYOCARDIAL INFARCTION</i> DUE TO (c) <i>CORONARY ARTERIOSCLEROSIS</i>					
INTERVAL BETWEEN ONSET AND DEATH <i>5 MINUTES</i>					
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m.	20d. INJURY OCCURRED White of work <input type="checkbox"/> Not white of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <i>Suitland Md.</i>	(County)	(State)
21. I certify that I attended the deceased from <i>JANUARY, 1958</i> , to <i>11 JUNE, 1958</i> , that I last saw the deceased alive on <i>11 JUNE, 1958</i> , and that death occurred at <i>11:45 PM</i> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>729 PERSHING DRIVE SILVER SPRING, MARYLAND</i>					
ACTUAL SIGNATURE <i>Joseph T. Kimble</i>	DATE SIGNED <i>11 JUNE, 1958</i>				
PHYSICIAN'S NAME (Type) <i>Seruch T. Kimble</i>					

22a. BURIAL <input type="checkbox"/> CREMATION REMOVAL (SPECIFY) <i>CREMATION</i>	22b. DATE THEREOF <i>6-13-58</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Cedar Hill</i>	22d. LOCATION (City, town, or county) <i>Suitland Md.</i>	(State)
23. FUNERAL DIRECTOR'S SIGNATURE <i>Joseph T. Kimble, D.C.</i>	ADDRESS <i>2122 Mass Ave NW</i>	24a. REC'D BY REGISTRAR DATE <i>JUN 16 '58</i>	24b. REGISTRAR'S SIGNATURE <i>Alfred Smith</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7092

CERTIFICATE OF DEATH

Reg. Dist. No. 215

07081

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be signed by the hospital or attending physician

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, pay the funeral director
 page 3 should be detached for use as the burial/transit permit. Then ~~fill in~~ move carbon papers. Pages 1, 2 & 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE District of Columbia		b. COUNTY				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 2 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington						
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital, Bethesda, Md.				d. STREET ADDRESS 2301 Conn. Ave., N.W., Apt. 31		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First Helen	Middle Newton	Last STITT	4. DATE OF DEATH Month June	Day 14	Year 1958				
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 11, 1876	9. AGE (In years last birthday) 82	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0	12. HRS Hours 0	13. MIN 0		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY - - -		11. BIRTHPLACE (State or foreign country) Alabama		12. CITIZEN OF WHAT COUNTRY? U. S. A.				
13. FATHER'S NAME James M. BENNETT			14. MOTHER'S MAIDEN NAME Susan S. NEWTON							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No	16. SOCIAL SECURITY NO. None		17. INFORMANT (Daughter) Helen K. NEWTON, same as #2		Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] Part I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a). DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO (c) Myocardial Infarction Anteriosclerotic heart disease 36 hrs.									INTERVAL BETWEEN ONSET AND DEATH	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)								
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	Day	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)			
21. I certify that I attended the deceased from June 12, 1958 , to June 14, 1958 , that I last saw the deceased alive on June 13, 1958 , and that death occurred at 12:30A.M. from the causes and on the date stated above									ADDRESS (Street, city or town, state)	DATE SIGNED
ACTUAL SIGNATURE <i>R. G. Muth</i>	M.D. U. S. Naval Hospital, NNMC								6-14-58	
PHYSICIAN'S NAME (Type) R. G. MUTH, LT, MC, USN	Bethesda, Maryland									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 6-16-58	22c. NAME OF CEMETERY OR CREMATORIUM Rock Creek Cemetery			22d. LOCATION (City, town, or county) Washington, D. C.		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <i>Gawler's</i> Joseph Gawler's & Sons, 1756 Penn. Ave., N.W.		ADDRESS Washington, D.C.			24a. REC'D BY REGISTRAR JUN 16 '58	24b. REGISTRAR'S SIGNATURE <i>C. L. Smith</i>				



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
7093 CERTIFICATE OF DEATH

07082

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) a. STATE		b. COUNTY	
Montgomery				1421 Mass Ave N.W.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
Kensington		9 mos		Washington, D.C.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM?			
Kensington Garden Sanitarium				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			

3. NAME OF DECEASED (Type or print)	First	Middle	Last	4. DATE OF DEATH	Month	Day	Year
Menzel	F		Stitt	June	14	1958	

5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday) yrs	10. IF UNDER 1 YEAR	11. IF UNDER 24 HRS
Female	White	WIDOWED <input checked="" type="checkbox"/>	Divorced <input type="checkbox"/>	July 27-1880	77	Months Days Hours Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
none		Maysville Ky	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME	Address
unobtainable	unobtainable	1st Ad-2-5540

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no or unknown)	16. SOCIAL SECURITY NO.	17. INFORMANT	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]
No		Mrs Margaret Putnam 1st 24-Mass-Ave. N.W.	PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)

DUE TO	Congestive Heart Failure	INTERVAL BETWEEN ONSET AND DEATH
422.2	Myocarditis	48 hrs
Conditions, if any which gave rise to immediate cause (a), slotting the underlying cause last.	(b)	1 year.
DUE TO		
(c)		

MEDICAL CERTIFICATION	PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)	19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
	Cerebrovascular accident	

20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)
---	---

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.	20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
19					

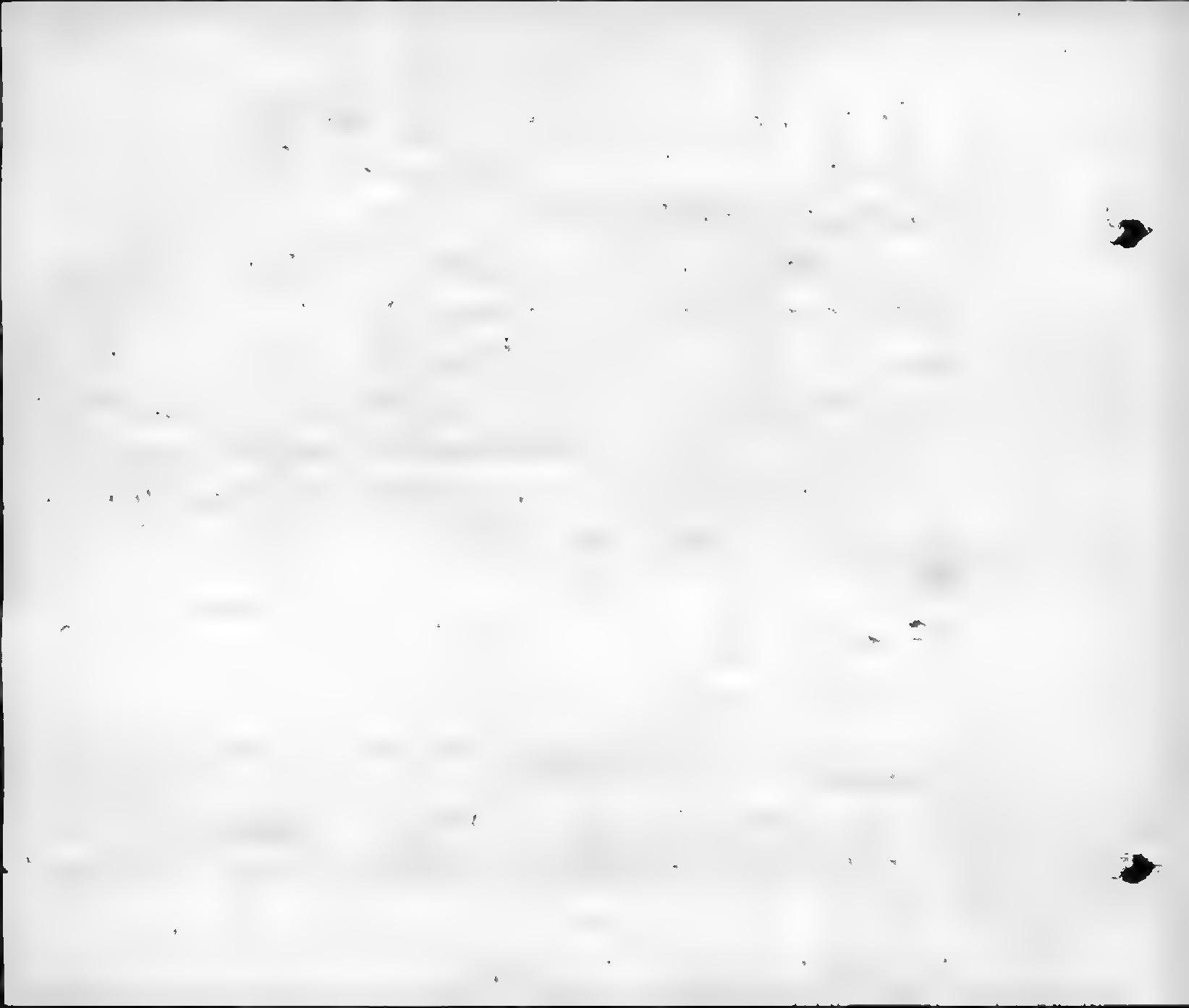
21. I certify that I attended the deceased from 5 Sept. 1957 to 14 June 1958 that I last saw the deceased alive on 14 June 1958, and that death occurred at 6:30 PM, from the causes and on the date stated above	ADDRESS (Street, city or town, state)	DATE SIGNED
---	---------------------------------------	-------------

ACTUAL SIGNATURE	Herbert Martyn Jr. M.D.	5029 Bethesda Ave
------------------	-------------------------	-------------------

PHYSICIAN'S NAME (Type)	HUBERT MARTYN JR	Bethesda Md	14 June 58
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22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORIUM	22d. LOCATION (City, town or county)	(State)
Burial	6/15/58	Maysville	Maysville, KY.	

23. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS	24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE
S.H. Hines Co.	2901-14 St. Washington D.C.	JUN 17 1958	Alvin J. Hines



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07083

6965

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE Md.		b. COUNTY Frederick		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville		c. LENGTH OF STAY IN 1b 1 yr. 3 mo.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Frederick				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 805 Crothers Lane		d. STREET ADDRESS 321 East Third Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Katie		First Katie	Middle Fraley	Last Stone	4. DATE OF DEATH June 26 1958	Month June	Day 26	Year 1958
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH March 18, 1879	9. AGE (In years last birthday) 79 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0	Hours 0	Min 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Feagerville, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.		
13. FATHER'S NAME George C. Stone		14. MOTHER'S MAIDEN NAME Ellen Fraley		Address				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO none		17. INFORMANT Betty R. Turner, 805 Crothers Lane				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							INTERVAL BETWEEN ONSET AND DEATH 9 days	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterio-sclerotic heart disease with aortic stenosis DUE TO Atherosclerosis (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Arterio-sclerotic heart disease with aortic stenosis							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b)						
20c. TIME OF INJURY Month, Day, Year Hour e. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from November 19, 1957, to June 26, 1958, that I last saw the deceased alive on June 17, 1958, and that death occurred at 10:30 AM, from the causes and on the date stated above. ACTUAL SIGNATURE Herman C. Maganzini PHYSICIAN'S NAME (Type) Herman C. Maganzini		ADDRESS (Street, city or town, State) 809 Viers Mill Road, Rockville, Maryland					DATE SIGNED June 26, 1958	
22a. BURIAL CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/28/58		22c. NAME OF CEMETERY OR CREMATORIAL Zion		22d. LOCATION (City, town or county) Feagerville Md		
23. FUNERAL DIRECTOR'S SIGNATURE William B. Hilton, Barnesville		ADDRESS Wm B Hilton, Barnesville		24a. REC'D BY REGISTRAR DATE JUL 1 1958		24b. REGISTRAR'S SIGNATURE Att. [Signature]		

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07084

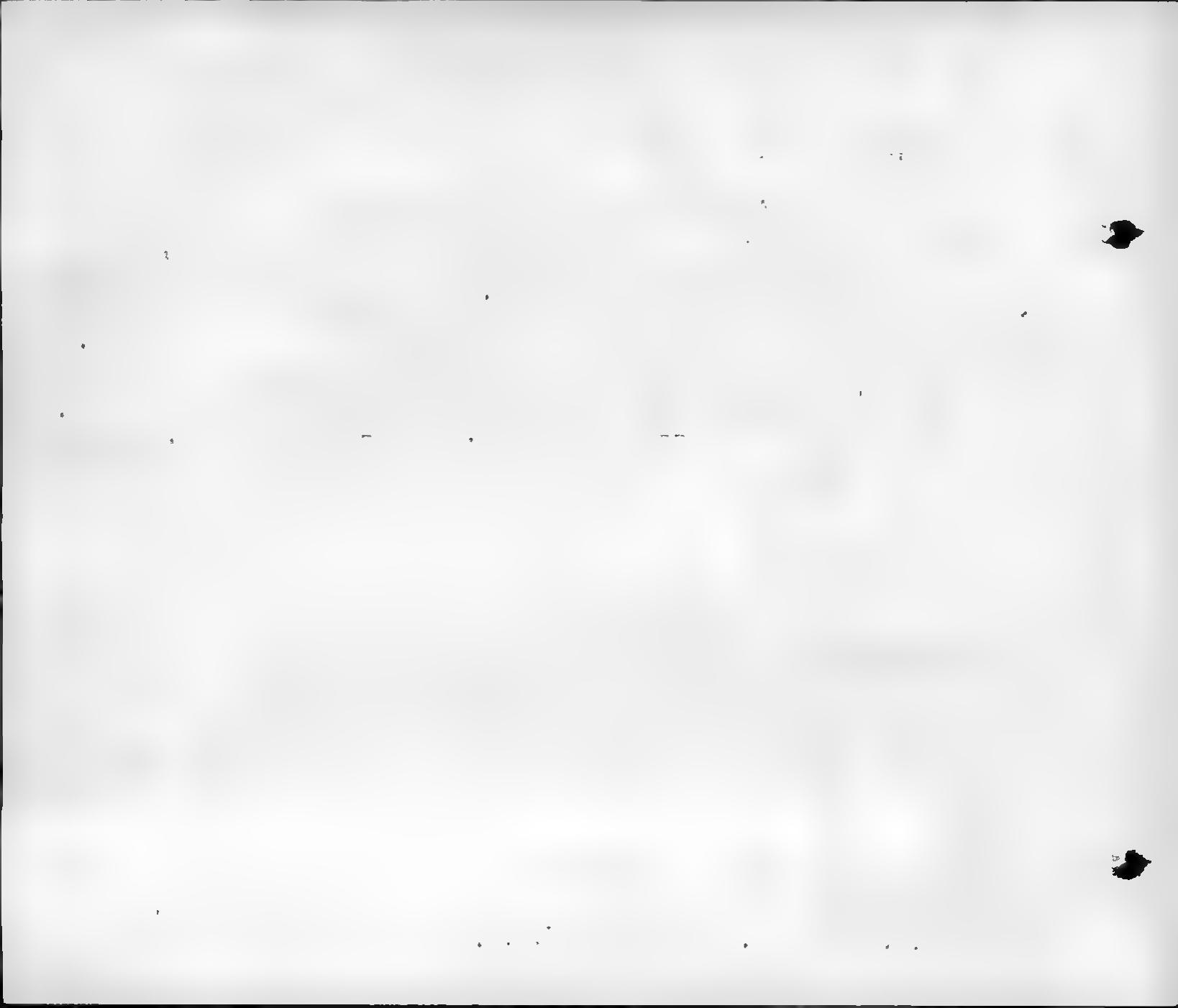
CERTIFICATE OF DEATH

Reg. Dist. No.

7094

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon palliers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH o COUNTY <i>Montgomery</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <i>Md.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Westgate</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Westgate</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <i>4914 Flint Drive, Westgate</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <i>Annie</i>	Middle <i>L</i>	Last <i>Sullivan</i>
4. SEX <i>female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Nov. 28, 1865</i>
9. AGE (In years last birthday) <i>92 yrs.</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS. Days <i>0</i>	12. Month <i>June</i>
13. FATHER'S NAME <i>George W. Haley</i>	14. MOTHER'S MAIDEN NAME <i>Martha Virginia Drew</i>	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY NO <i>---</i>
17. INFORMANT <i>Ruth S. Horner</i>	18. ADDRESS <i>4914 Flint Dr. Westgate,</i>	19. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	20. MD.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>UREMIA</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED [Enter nature of injury in Part I or Part II of item 18.]		
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>---</i>	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>1956</i> , to <i>June 12, 1958</i> , that I last saw the deceased alive on <i>June 11, 1958</i> , and that death occurred at <i>7 1/2 A.M.</i> from the causes and on the date stated above. ACTUAL SIGNATURE <i>Edward W. Nicklas</i> M.D. ADDRESS (Street, city or town, state) <i>4830 U St. N.W.</i> DATE SIGNED <i>1958</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial 6/16/58</i>	22b. DATE THEREOF <i>6/16/58</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Glenwood Cemetery</i>	22d. LOCATION (City, town, or county) (State) <i>Washington, D.C.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>The S.H. Hines Co.</i>	ADDRESS <i>2901 14th St., N.W.</i>	24a. REC'D BY REGISTRAR DATE <i>JUN 13 '58</i>	24b. REGISTRAR'S SIGNATURE <i>Albert L. French</i>



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07685

Reg. Dist. No. 215

7095

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE West Virginia		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN lb 5 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Charleston			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Maryland		d. STREET ADDRESS 404 Thompson Apt 9A		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Kathryn	Middle Isabel	Last SULLIVAN	4. DATE OF DEATH June 9 1958	Month June	Day 9	Year 1958
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-4-15	9. AGE (In years from birthday) 42 yrs	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0	12. HOURS 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Ohio		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Stephen MARONEY			14. MOTHER'S MAIDEN NAME Edith NEASE				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unknown		16. SOCIAL SECURITY NO Unknown		17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cirrhosis of Liver DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)							
INTERVAL BETWEEN ONSET AND DEATH 6 Years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6-1- 1958 to 6-9- 1958 , that I last saw the deceased alive on 6-9-58 , and that death occurred at 3:45 P.M. from the causes and on the date stated above							
ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md. DATE SIGNED							
ACTUAL SIGNATURE <i>Gerald I. Shugoll</i> M.D. U.S. NAVAL HOSPITAL, BETHESDA, MD. 6-9-58							
PHYSICIAN'S NAME (Type)		U.S. NAVAL HOSPITAL, BETHESDA, MD.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-10-58		22c. NAME OF CEMETERY OR CREMATORIUM Montgomery Memorial Park		22d. LOCATION (City, town, or county) London, West Virginia (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Gerald L. Humphrey</i>		ADDRESS <i>Bethesda, Md.</i>		24a. REC'D BY REGISTRAR DATE JUN 11 '58		24b. REGISTRAR'S SIGNATURE <i>A. L. Smith</i>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07086

7096 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY

Montgomery

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Gaithersburg

c. LENGTH OF STAY IN 1b
28 yrsd. NAME OF HOSPITAL (If not in hospital, give street address)
OR INSTITUTION

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE

Maryland

b. COUNTY

Montgomery

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Gaithersburg

Rural

3. NAME OF
DECEASED
(Type or print)First
VincentMiddle
BurkeLast
Tabler4. DATE
OF
DEATHMonth
JuneDay
19
Year
58

5. SEX

6. COLOR OR RACE

7. MARRIED NEVER MARRIED

8. DATE OF BIRTH

9. AGE (in years
last birthday)IF UNDER 1 YEAR
Months Days Hours Min.

Male

White

WIDOWED DIVORCED

Mar 1st 1886

72 yrs

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Salesman

Merchant

Hyattstown, Md.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

George T Tabler

14. MOTHER'S MAIDEN NAME

Ida Cooke

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown)

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

Mary M. Tabler, Gaithersburg, RFD. 2, Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

Heart failure.

INTERVAL BETWEEN
ONSET AND DEATH

X DUE TO

Conditions, if any, which
gave rise to immediate
cause (a), stating the under-
lying cause last.

(b)

DUE TO

(c)

Hyper tension Generalized Arteroscler-

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY
PERFORMED?
YES NO 20a. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF DEATH
(If either, notify MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED: (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year

Month
Aug
a. m.
p. m.Day
19

20d. INJURY OCCURRED

While
at workNot while
at work20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I attended the deceased from 1955, 19, to 6/22, 1958, that I last saw the deceased alive on 6/25, 1958, and that death occurred at 11:00 P.M. from the causes and on the date stated above.

ADDRESS (Street, city or town, state)

DATE SIGNED

ACTUAL
SIGNATURE Luciano L. Loal M.D. 108 N. Frederick Ave.PHYSICIAN'S
NAME (Type) Luciano L. Loal M.D. Gaithersburg, Md.22a. BURIAL, CREMATION,
REMOVAL (Specify)

6-29-08

22b. DATE THEREOF

Parklawn

22c. NAME OF CEMETERY OR CREMATORIUM

22d. LOCATION (City, town, or county)

Rockville

(State)

Md.

23. FUNERAL DIRECTOR'S SIGNATURE

Ernest C. Gartner, Gaithersburg, Md.

ADDRESS

24a. REC'D BY REGISTRAR

Date JUN 30 '58

24b. REGISTRAR'S SIGNATURE

Alvin Smith

TO HOS **FOR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 4 hours after death; Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be fitted with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07087

3097

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)	
Montgomery Maryland		a. STATE b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
RURAL and give nearest town Bethesda, Md.		Wheaton, D.C.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. STREET ADDRESS	
Jubilee		5436-30th St. N.W.	
f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last		4. DATE OF DEATH Month Day Year	
Marie		Tammian June 7 1958	
5. SEX f. White		5. COLOR OR RACE MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 6. DATE OF BIRTH	
		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 7. AGE (in years last birthday) 50 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
Housewife		Housewife	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Greece Turkey		U.S.A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
John Lambrianos		Marie M. Kitavitis	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO	
(If yes, give war or dates of service)		17. INFORMANT	
		Paul Tammian - 5436 30th St. N.W.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]		Address	
PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH 2 months	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first.		Two conditions, renal.	
{ (b) DUE TO (c)		Virus infection	
4 month			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20c. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 23 May, 1958, to 7 June, 1958, that I last saw the deceased alive on 1 June, 1958, and that death occurred at 10:30 AM, from the causes and on the date stated above.			
ACTUAL SIGNATURE		ADDRESS (Street, city or town, state)	
HERBERT MARTYN Jr.		5029 BETHESDA AVE	
M.D.		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 6/10/1958	
22c. NAME OF CEMETERY OR CREMATORIAL		22d. LOCATION (City, town, or county) (State)	
WASH, 5, D.C.		WATERTOWN, MASSACHUSETTS	
23. FUNERAL DIRECTOR'S SIGNATURE MARTIN W. HYSONG CO. INC. 1300 - N. STREET, N.W.		24a. REC'D BY REGISTRAR DATE JUN 1 - '58	
ADDRESS		24b. REGISTRAR'S SIGNATURE Alvarez	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07088

7098

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CRESTVIEW		b. COUNTY MONTGOMERY	
c. LENGTH OF STAY IN 1B ONE MONTH		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CRESTVIEW	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4811 BAYARD BLVD.		d. STREET ADDRESS 4811 BAYARD BLVD.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First MARTHA	Middle ALDIE	Last TAYLOR
4. DATE OF DEATH	Month JUNE	Day 1	Year 1958
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH OCT. 6, 1880
9. AGE (In years last birthday) 77 yrs.	10. FUNDER 1 YEAR Months 7	11. IF UNDER 24 HRS Days 0	12. Hours 0
13. PARENT'S NAME ALFRED EDWARD TAYLOR	14. MOTHER'S MAIDEN NAME MARTHA ALICE LOVELESS	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES	
16. SOCIAL SECURITY NO. 577-16-2549		17. INFORMANT MARY ANGELA HAVIK SHAW	Address 4811 BAYARD BLVD.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY FAILURE		INTERVAL BETWEEN ONSET AND DEATH 1 YR.	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. 170X		DUE TO CARCINOMATOSIS	
(b)		DUE TO CARCINOMA OF BREAST	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21. I certify that I attended the deceased from MAY 31 , 19 58 to JUNE 1 , 19 58 , that I last saw the deceased alive on JUNE 1 , 19 58 , and that death occurred at 8:18 A.M. from the causes and on the date stated above. ACTUAL SIGNATURE Edward J. Witowski, Jr. M.D.	
22c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.	
20d. ADDRESS (Street, city or town, state) SUITE 400, 8218 WISCONSIN AVE., BETHESDA 14, MARYLAND		20e. (City or town) (County) (State) ARLINGTON VA	
22d. LOCATION (City, town, or county) ARLINGTON VA		22b. DATE THEREOF JUN 1 1958	
22e. NAME OF CEMETERY OR CREMATORIAL ARLINGTON NATIONAL		22f. REMOVAL (Specify) BURIAL	
23. FUNERAL DIRECTOR'S SIGNATURE H. Don. DeVol 2224 - W. 2. 74		24a. REC'D BY REGISTRAR DATE JUN 4 1958	
ADDRESS		24b. REGISTRAR'S SIGNATURE R. DeVol	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07089

7099

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE		
<i>Montgomery Co., Maryland</i>		<i>Maryland</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN lb	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		
<i>Bethesda</i>	<i>3 1/2 mos.</i>	<i>Silver Spring, MD</i>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION	d. STREET ADDRESS			
<i>Suburban Hospital</i>	<i>1926 Grace Church Rd.</i>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First	Middle	Last	4. DATE OF DEATH Month Day Year
<i>Elizabeth</i>	<i>Louisa</i>	<i>Terhune</i>	<i>June 10</i>	<i>1958</i>
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years lost birthday) yrs. IF UNDER 1 YEAR Months Days Hours Min.
<i>F</i>	<i>white</i>		<i>Feb. 26, 1875</i>	<i>75</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)
<i>house wife</i>		<i>Own home</i>		<i>Philadelphia, Pa.</i>
13. FATHER'S NAME		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		
<i>Richard Seymour</i>		<i>Elizabeth Fillmore</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT
<i>No</i>		<i>none</i>		<i>Mrs. Myrtle Schwartz</i>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		DUE TO		
<i>Shock and Toxemia</i>		<i>Intestinal infarction, ileum</i>		
DUE TO		<i>Mesenteric venous thrombosis</i>		
Conditions if any, which gave rise to immediate cause (a), stating the underlying cause lost.				
(b) <i>Intestinal infarction, ileum</i>		1 day		
(c) <i>Mesenteric venous thrombosis</i>		1 day		
DUE TO		1 day		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		INTERVAL BETWEEN ONSET AND DEATH 1 day		
<i>Cerebral infarctions due to arteriosclerosis</i>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from _____, 19_____, to _____, 19_____, that I last saw the deceased alive on _____, 19_____, and that death occurred at _____ M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state)		
ACTUAL SIGNATURE - <i>George Shape</i>		M.D. <i>10511 Summit Ave</i>		
PHYSICIAN'S NAME (Type) <i>George Shape, M.D.</i>		DATE SIGNED <i>6/13/58</i>		
22a. BURIAL, CREMATION, REMOVAL (Specify) & BURIAL		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIUM
<i>Burial</i>		<i>6/14/58</i>		<i>MT. MORIAH CEMETERY</i>
22d. LOCATION (City, town, or county) (State)		<i>PHILADELPHIA, PA.</i>		
23. FUNERAL DIRECTOR'S SIGNATURE		24a. REC'D BY REGISTRAR DATE JUN 13 '58		
ADDRESS		24b. REGISTRAR'S SIGNATURE <i>Albert L. Smith</i>		
<i>Warren E. Lumpfrey</i>		<i>SILVER SPRING, MD.</i>		

TO HOSPITAL OR ATTENDANT PHYSICIAN: The law requires that the death certificate be returned within 24 hours after death, by the funeral director.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1

2

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07090

7100

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Md.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>9810 George Lane S.D.</i>		b. COUNTY <i>Md.</i>	
c. LENGTH OF STAY IN 1b <i>2 days</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Wheaton, Md.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Maple Lane San.</i>		d. STREET ADDRESS <i>12030 Centennial</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <i>Mary</i>	Middle <i>Katherine</i>	Last <i>Tull</i>
4. DATE OF DEATH	Month <i>6</i>	Day <i>24</i>	Year <i>1958</i>
5. SEX <i>F</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>June 8, 1894</i>
9. AGE (In years last birthday) <i>64 yrs</i>	10. IF UNDER 1 YEAR Months <i>6</i>	11. IF UNDER 24 HRS Days <i>0</i>	12. IF UNDER 24 HRS Hours <i>0</i>
13. FATHER'S NAME <i>—</i>	14. MOTHER'S MAIDEN NAME <i>KIDDER UNKNOWN</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY NO. <i>None</i>	17. INFORMANT <i>Lucille Nestler</i>	Address <i>12030 Centennial</i>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>UREMIA</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arteriosclerotic Heart Disease</i> DUE TO (c) <i>Congestive Heart failure</i> INTERVAL BETWEEN ONSET AND DEATH <i>1-2 weeks</i> <i>years</i> <i>years</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Diabetes mellitus and degenerative illness.</i>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.) <i>—</i>		
20c. TIME OF INJURY Hour a. m. p. m. <i>— 19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> At work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>—</i>	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>November 1, 1956</i> to <i>1958</i> , that I last saw the deceased alive on <i>1958</i> , and that death occurred at <i>M.</i> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>—</i> DATE SIGNED <i>—</i>			
ACTUAL SIGNATURE <i>W.W. Chambers</i>	PHYSICIAN'S NAME (Type) <i>ST. V'LOUR GRIFFITH, M.D.</i>		
22a. BURIAL, CREATION, Specify <i>BURIAL</i>	22b. DATE THEREOF <i>6-26-58</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>ARLINGTON NATL</i>	22d. LOCATION (City, town, or county) <i>FT MYER, VA.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>W.W. CHAMBERS, CO.</i>	ADDRESS <i>1400 CHAPIN ST NW</i>	24a. REC'D BY REGISTRAR DATE <i>JUN 25 '58</i>	24b. REGISTRAR'S SIGNATURE <i>W.W. Chambers</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-travel permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07091

7101

CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland		b. COUNTY Montgomery		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 14 hours		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda X		d. STREET ADDRESS 4502 Oxendale St.		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Bernice		First	Middle	Last	4. DATE OF DEATH June 17 1958	Month	Day	Year
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH July 10 1915	9. AGE (In years last birthday) 42 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bookkeeper		10b. KIND OF BUSINESS OR INDUSTRY Country Club		11. BIRTHPLACE (State or foreign country) South Carolina		12. CITIZEN OF WHAT COUNTRY America		
13. FATHER'S NAME Gaiel A. Setzer		14. MOTHER'S MAIDEN NAME Myrtle Bradley						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO Unknown		17. INFORMANT Lila L Swartz Arlington, Va		Address 11023 N. Barton		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 490.0		DUE TO Coronary Thrombosis		INTERVAL BETWEEN ONSET AND DEATH 36 HRS				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)		DUE TO ARTERIOSCLEROTIC HEART DISEASE		LYRS				
(c)								
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from June 16 1958 to June 17 1958 , that I last saw the deceased alive on June 16 1958 , and that death occurred at 3:00 AM , from the causes and on the date stated above. ACTUAL SIGNATURE Leo J. Donovan PHYSICIAN'S NAME (Type) Leo J. DONOVAN M.D.		ADDRESS (Street, city or town, state) 8016 Germantown Rd. Bethesda MD		DATE SIGNED 14 JUN 1958				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/19/58		22c. NAME OF CEMETERY OR CREMATORIUM Burtonsville Cemetery		22d. LOCATION (City, town, or county) Burtonsville, Maryland (State)		
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		ADDRESS Bethesda, Maryland		24e. REC'D BY REGISTRAR 18 '58		24f. REGISTRAR'S SIGNATURE W. Beouch		



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7102

CERTIFICATE OF DEATH

07092

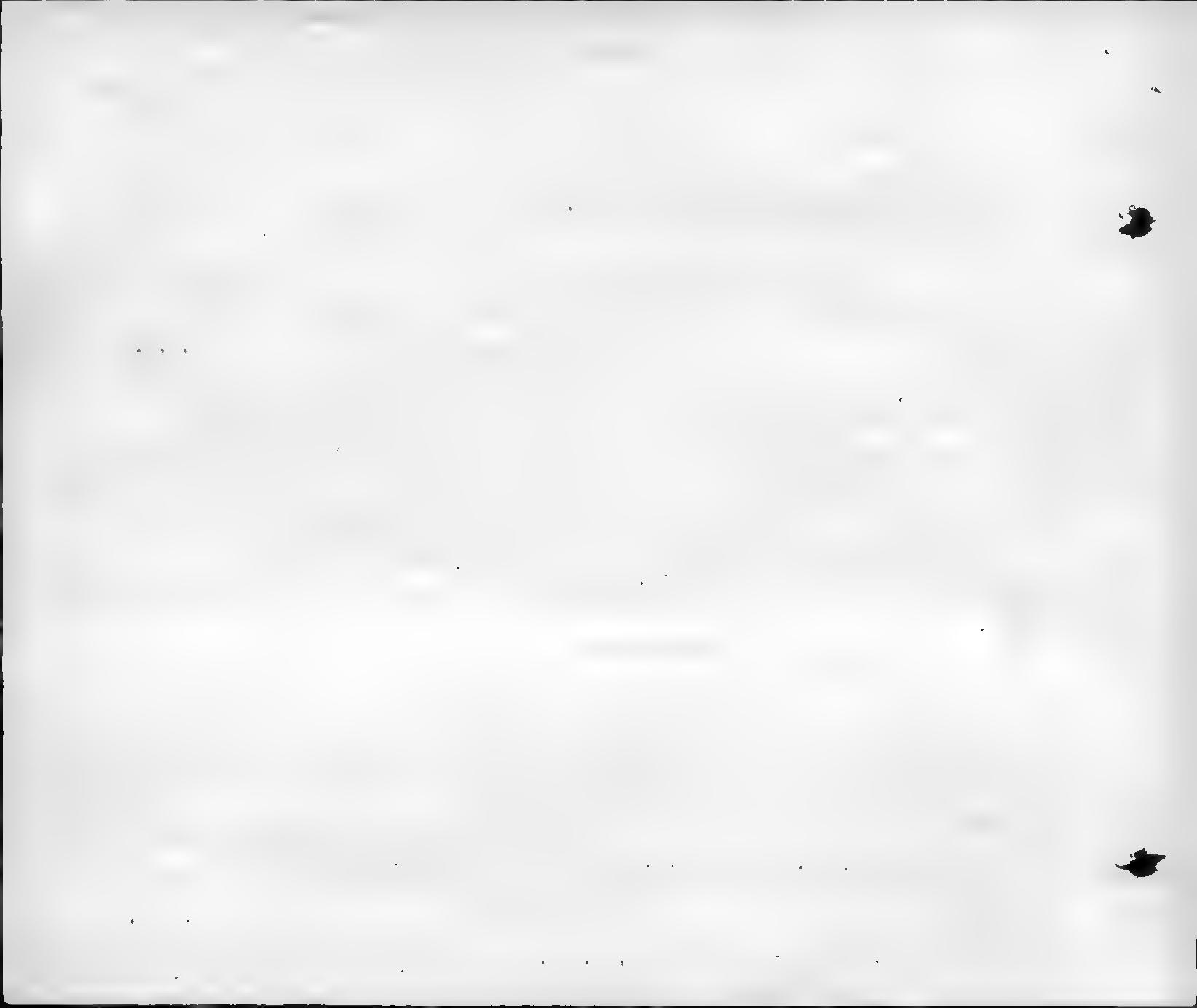
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN b. 2 days		2 USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE West Virginia		b. COUNTY	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Martinsburg			
3. NAME OF DECEASED (Type or print)		First Edmund	Middle Harvey	Last Unger	4. DATE OF DEATH May 3, 1943	Month June	Day 28	Year 1958	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH May 3, 1943	9. AGE (In years lost birthday) 15 yrs	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days	Hours	Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Mason L. Unger		14. MOTHER'S MAIDEN NAME Eleanor Hoffmaster							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) no		16. SOCIAL SECURITY NO none		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a). Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b). DUE TO		longitudinal heart failure		INTERVAL BETWEEN ONSET AND DEATH 12 days					
(c). DUE TO		cardiac valvular insufficiency		15 years					
		Marfan's syndrome							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Martinsburg		(County)	(State)
21. I certify that I attended the deceased from June 26, 1958, to June 28, 1958, that I last saw the deceased alive on June 28, 1958, and that death occurred at 5:20 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center National Institutes of Health Bethesda 14, Maryland									
ACTUAL SIGNATURE Physician's NAME (Type) Joel H. Feigon, M.D.						DATE SIGNED 6/29/58			
22a. BURIAL, CREMAT. ON, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/1/58		22c. NAME OF CEMETERY OR CREMATORIUM Rosedale Cemetery		22d. LOCATION (City, town, or county) Martinsburg, W. Va.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Howard K. Brown-Martinsburg, W. Va.		ADDRESS		24a. REC'D BY REGISTRAR DATE JUL 1 '58		24b. REGISTRAR'S SIGNATURE W. E. Deuch			

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then ~~please~~ remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07093

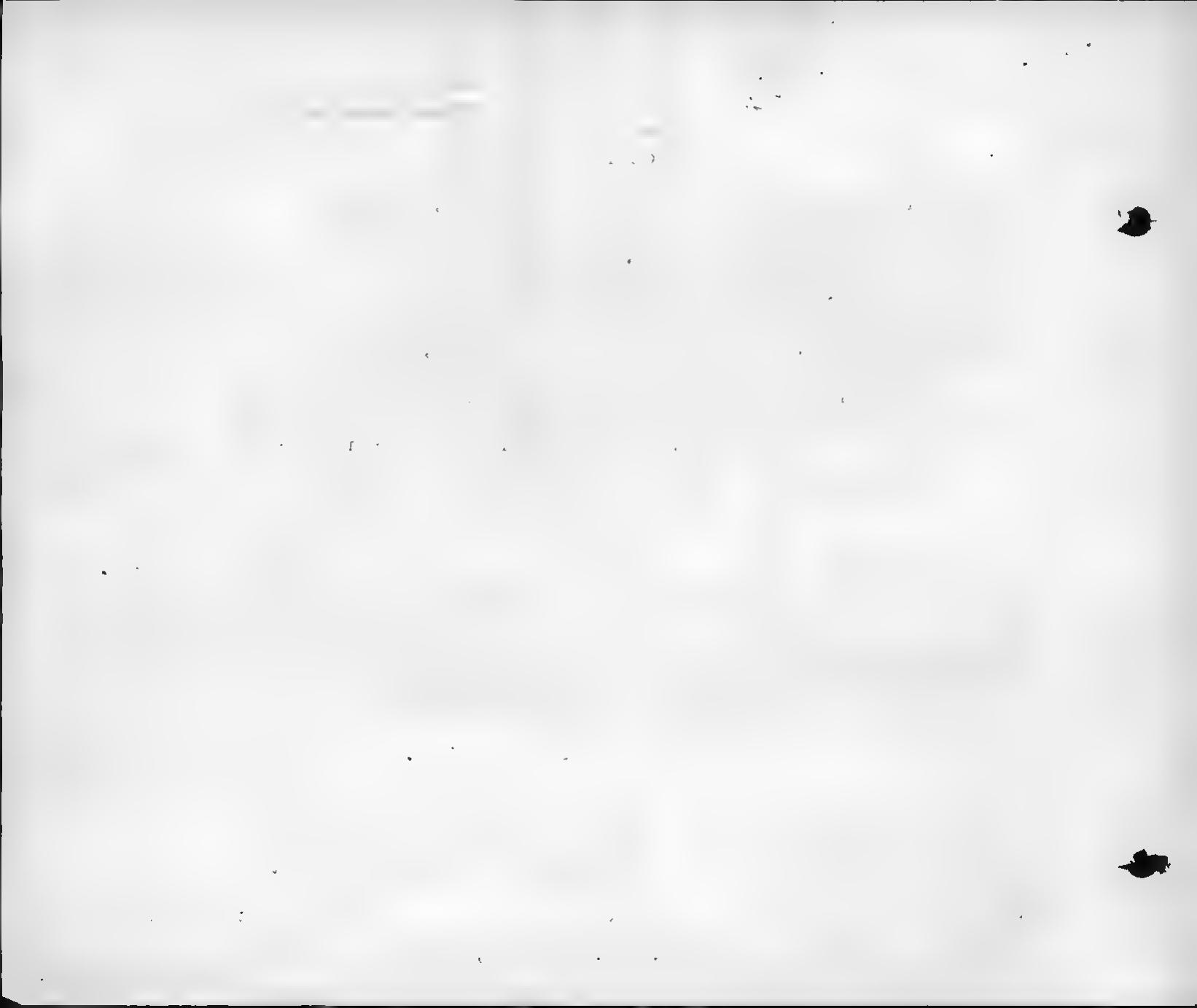
6957

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park		b. COUNTY Montgomery				
c. LENGTH OF STAY IN 1b 7 months		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 5805 Kingswood Road				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Oakhaven Rest Home		d. STREET ADDRESS Bethesda, Maryland				
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print)	First FRANK	Middle W.	Last VANZANT			
4. DATE OF DEATH	Month June	Day 22	Year 19 58			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 27, 1888			
9. AGE (In years last birthday) 69 yrs	10. IF UNDER 1 YEAR Months 10	11. IF UNDER 24 HRS Days 25	12. IF UNDER 24 HRS Hours 10			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired-Ice Manu.	10b. KIND OF BUSINESS OR INDUSTRY Self-employed	11. BIRTHPLACE (State or foreign country) Ontario, Canada	12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Uriah Van Zant	14. MOTHER'S MAIDEN NAME Rachel Hamilton					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. Unknown	17. INFORMANT Calvin Vane-son-in-law - Same Item #2	Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral hemorrhage</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last } (b) _____ DUE TO (c) <i>High blood pressure</i>						
INTERVAL BETWEEN ONSET AND DEATH						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour: a.m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office, etc.)	20f. (City or town)	(County)	(State)
21. I certify that I attended the deceased from June 22 , 19 58 , to June 22 , 19 58 , that I last saw the deceased alive on June 22 , 19 58 , and that death occurred at 4:30 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Becker County Minnesota						
DATE SIGNED 6/23/1958						
ACTUAL SIGNATURE <i>Uriah Van Zant</i>		PHYSICIAN'S NAME (Type) <i>Dr. Uriah Van Zant</i>				
22a. BURIAL, CREMATION, REMOVAL (Specify) Bur-transit		22b. DATE THEREOF 6/23/1958	22c. NAME OF CEMETERY OR CREMATORIUM Oak Grove	22d. LOCATION (City, town, or county) (State) Becker County Minnesota		
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		ADDRESS 7557 Wis. Ave. Bethesda, Md.	24a. REC'D BY REGISTRAR DATE JUN 25 '58	24b. REGISTRAR'S SIGNATURE Alfredus		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



FOR STATE
HEALTH DEPT.

TO DIRECTOR: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 24 hours after death.

VS ATSM
SM 2-57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7103 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07094

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Maryland		b. COUNTY Montgomery		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN MD D.O.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington		d. STREET ADDRESS 17100 Ashwood Drive		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Suburban Hospital				e. IS RESIDEN ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Charles Sebastian Voigt Jr.		First	Middle	Last	4. DATE OF DEATH June 1, 1958	Month	Day	Year
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 19, 1923	9. AGE (In years less than 100) 34 yrs.	10. UNDER 24 HRS Months	11. BIRTHPLACE (State or foreign country) D.C.	12. CITIZEN OF WHAT COUNTRY? USA	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Prof. Bridge Instructor		10b. KIND OF BUSINESS OR INDUSTRY		11. INFORMANT		Address		
13. FATHER'S NAME Charles S. Voigt Sr.		14. MOTHER'S MAIDEN NAME Mary A. Clover						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) WW II		16. SOCIAL SECURITY NO yes		17. INFORMANT Hosp. Record		INTERVAL BETWEEN ONSET AND DEATH		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral Concussion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) Fractures of Skull DUE TO (c) Lacerations, Liver & Spleen Auto Accident Immediate								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL SEASIDE CONDITION GIVEN IN PART I (d) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>								
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Driver of auto. that left him away struck tree						
20c. TIME OF INJURY Hour 3:30 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) hi away		20f. (City or town) Kensington	(County) Md.	(State)
6/21/58 19								
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE <i>Frank J. Broschart</i>		MD		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 6/21/58		
EXAMINER'S NAME (Type) Frank J. Broschart				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
22a. BURIAL, CREMATION, OR REMOVAL (Specify) Burial		22c. NAME OF CEMETERY OR CREMATORIUM Arlington National		22d. LOCATION (City, town, or county) Arlington, Virginia		(State)		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert A. Brumley</i>		ADDRESS <i>Bethesda</i>		24a. REC'D BY REGISTRAR DATE JUN 25 '58		24b. REG STAR'S SIGNATURE <i>Debra</i>		



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07095

Item 9 7-15-58

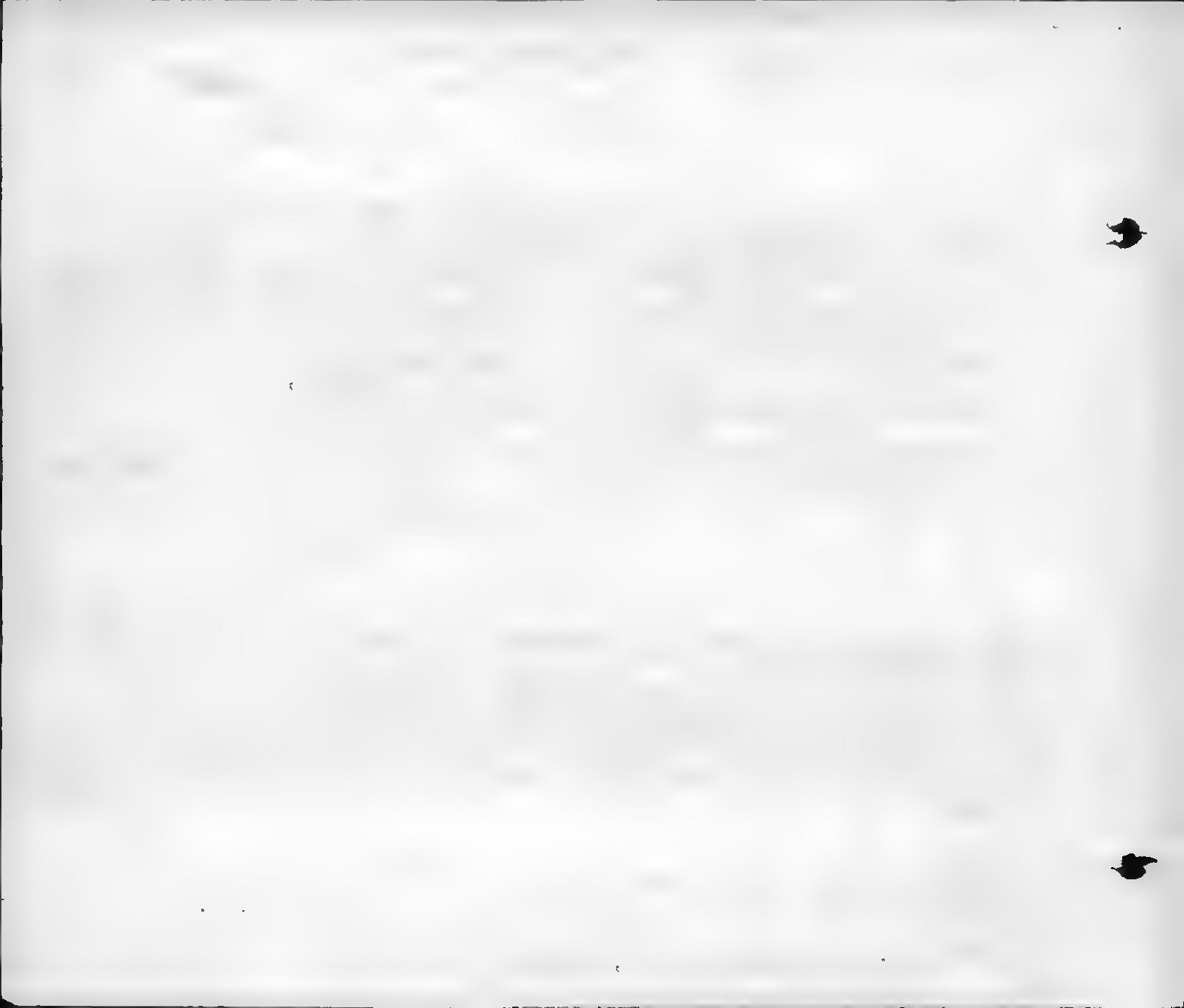
CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

7104							
1. PLACE OF DEATH a. COUNTY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission)			
<i>Montgomery</i>				a. STATE		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
<i>Bethesda</i>		<i>30 hrs</i>		<i>Washington, D.C.</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. STREET ADDRESS		f. IS RESIDENCE ON A FARM?			
<i>Suburban</i>		<i>5415 Connecticut Ave NW</i>		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		4. DATE OF DEATH		Month		Day Year	
<i>Elizabeth Marie Waeber</i>		<i>May 8, 1958</i>		6		22 1958	
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH	
<i>F</i>		<i>W</i>		<i>WIDOWED <input checked="" type="checkbox"/></i>		<i>May 8, Approx. 72 yrs.</i>	
9. AGED (In years last birthday)		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. KIND OF BUSINESS OR INDUSTRY		12. IF UNDER 1 YEAR IF UNDER 24 HRS	
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. KIND OF BUSINESS OR INDUSTRY		12. IF UNDER 1 YEAR IF UNDER 24 HRS		Months Days Hours Min.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO	
<i>Korschken John A</i>		<i>Mueller</i>		<i>No</i>		<i>None</i>	
17. INFORMANT		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		<i>Congestive heart failure</i>		20. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		<i>- 12 hr.</i>	
DUE TO		<i>arteriosclerosis</i>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		<i>20 yrs.</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		(b) <i>arteriosclerosis</i>		20c. TIME OF INJURY Month, Day, Year		20d. INJURY OCCURRED	
DUE TO		(c)		Hour a.m. p.m.		White Not white at work <input type="checkbox"/> at work <input type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		<i>Severe anemia - anemia</i>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year		20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
Hour a.m. p.m.		White Not white at work <input type="checkbox"/> at work <input type="checkbox"/>					
21. I certify that I attended the deceased from		<i>1954</i> , 19		<i>late</i> , 19		ADDRESS (Street, city or town, state)	
alive on		<i>22 June 1958</i>		<i>4:35 PM</i> from the causes and on the data stated above		DATE SIGNED	
ACTUAL SIGNATURE		<i>John G. Bell</i>		M.D.		<i>7936 Georgetown Rd. 23 Jun 58</i>	
PHYSICIAN'S NAME (Type)		<i>John G. Bell</i>				<i>Bethesda Md.</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIUM		22d. LOCATION (City, town, or county) (State)	
<i>Burial</i>		<i>6/26/58</i>		<i>Rock Creek</i>		<i>Washington, D.C.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
<i>Robert A. Pumphrey-Bethesda, Maryland</i>				<i>JUN 25 '58</i>		<i>Alfred E. L.</i>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

07096

Reg. Dist. No.

7105

1. PLACE OF DEATH a. COUNTY		Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)	
				a. STATE	Maryland
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1B Silver Spring 5 yrs.		b. COUNTY	Montgomery
				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
				Silver Spring	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
8712 Colesville Rd. Apt. 309		8712 Colesville Rd. Apt. 309			
3. NAME OF DECEASED (Type or print)		First Edward	Middle Cosworth	Last Walker	4. DATE OF DEATH Month June 13 Year 1958
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH June 27, 1878	9. AGE (In years lost birthday) 79 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist		10b. KIND OF BUSINESS OR INDUSTRY Naval Gun Factory		11. BIRTHPLACE (State or foreign country) Washington, D. C.	
12. CITIZEN OF WHAT COUNTRY USA					
13. FATHER'S NAME Richard A. Walker		14. MOTHER'S MAIDEN NAME SOPHIA ALLEN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown) No		16. SOCIAL SECURITY NO. 577-28-3726		17. INFORMANT Richard A. Walker, 10.217 Southmoor Dr.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>metastatic Carcinoma to rib + spine</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) <i>Regrowth of carcinoma of prostate</i> 1 year DUE TO (c)				Silver Spine INTERVAL BETWEEN ONSET AND DEATH 6 mo	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>April 15</i> , 1958, to <i>June 13</i> , 1958, that I last saw the deceased alive on <i>June 12</i> , 1958, and that death occurred at <i>12:50 PM</i> , from the causes and on the date stated above.					
ACTUAL SIGNATURE PHYSICIAN'S NAME (Type)		<i>D.B. Washington</i>		ADDRESS (Street, city or town, state) <i>6234 7th Ave. Wash DC 6/13/58</i>	
DATE SIGNED <i>6/13/58</i>					
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 6/16/58		22c. NAME OF CEMETERY OR CREMATORIUM Parklawn Cemetery	
22d. LOCATION (City, town, or county) Montgomery County, Maryland		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <i>E.S. & Humphrey,</i>		ADDRESS Silver Spring, Md.		24a. REC'D BY REGISTRAR DATE JUN 16 '58	
				24b. REGISTRAR'S SIGNATURE <i>John Smith</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with
 page 3 should be detached for use as the burial-trust Permit. Then please remove carbon papers. Logs 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07097

6958

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE Maryland		b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park		c. LENGTH OF STAY IN 1b 37 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 7317 Takoma Avenue				d. STREET ADDRESS 7317 Takoma Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Frederick R. Waterholter		First	Middle	Last	4. DATE OF DEATH Month March 3	Day	Year 1958
S. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH March 10, 1882	9. AGE (In years from birth) 76 yrs	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0	12. IF UNDER 24 HRS Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bricklayer		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or Foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Frederick Waterholter		14. MOTHER'S MAIDEN NAME Kate Miller					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 578-03-1224		17. INFORMANT Mrs. Melvina E. Waterholter, 7317 Takoma Avenue		Address Takoma Park, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)						INTERVAL BETWEEN ONSET AND DEATH 8 weeks	
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral hemorrhage							
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost		(b) Senile Arteriosclerosis					
DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Congestive heart failure						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) falling down					
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) M.D. 2112 Wilson Ave. 3 years 1958		(County) D.C. (State) MD	
21. I certify that I attended the deceased from 29 May 1958 to 3 June 1958 , that I last saw the deceased alive on 29 May 1958 , and that death occurred at 4407 M.D. 2112 Wilson Ave. 3 years 1958 from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE F. B. Queen PHYSICIAN'S NAME (Type) F. B. Queen							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 6/6/58		22c. NAME OF CEMETERY OR CREMATORIUM Rock Creek Cemetery		22d. LOCATION (City, town, or county) Washington, D. C. (State) MD	
23. FUNERAL DIRECTOR'S SIGNATURE Warren G. Humphrey		ADDRESS Silver Spring, Md.		24a. REC'D BY REGISTRAR DATE JUN 9 '58		24b. REGISTRAR'S SIGNATURE Alvarez	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07098

6959

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Montgomery</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		c. LENGTH OF STAY IN 1b <i>DOA.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>2004 Hanover St.</i>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Washington Sanitarium & Hospital</i>		d. STREET ADDRESS <i>Silver Spring Md.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <i>Weakley, Irene Mamie</i>		4. DATE OF DEATH Month <i>June</i>	Day <i>6</i>	Year <i>1958</i>					
5. SEX <i>Female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH <i>July 28, 1901</i>	9. AGE (In years lost birthday) yrs. <i>56</i>	10. IF UNDER 1 YEAR Months <i>0</i>		IF UNDER 24 HRS Days <i>0</i>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Stanley, Virginia</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>			
13. FATHER'S NAME <i>William Thomas</i>		14. MOTHER'S MAIDEN NAME <i>Virginia Lamb</i>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes or no or unknown) <i>No</i>		16. SOCIAL SECURITY NO			
17. INFORMANT <i>Hospital Records & husband of Deceased</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary insufficiency</i> DUE TO 4-5.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <i>Myocardial myocardial infarction</i> DUE TO (b) <i>Coronary arteriosclerosis</i> DUE TO (c)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While Not while at work at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Stanley</i>		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <i>May 28, 1958</i> , to <i>June 6, 1958</i> , that I last saw the deceased alive on <i>June 5, 1958</i> , and that death occurred at <i>10:55 AM</i> , from the causes and on the date stated above.								ADDRESS (Street, city or town, state) <i>8737 Georgia Ave Silver Spring Md. June 6, 1958</i>	DATE SIGNED <i>June 6, 1958</i>
ACTUAL SIGNATURE <i>Aaron H. Traum</i>		PHYSICIAN'S NAME (Type) <i>Family Serv.</i>		22e. NAME OF CEMETERY OR CREMATORIAL <i>Family Serv.</i>		22d. LOCATION (City, town, or county) <i>Stanley</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial 6-8-58</i>		22b. DATE THEREOF <i>6-8-58</i>		22c. ADDRESS <i>8737 Georgia Ave Silver Spring Md. June 6, 1958</i>		(State) <i>Va.</i>			
23. FUNERAL DIRECTOR'S SIGNATURE <i>Budley Funeral Home Luray Va.</i>		24a. REC'D BY REGISTRAR DATE <i>JUN 9 '58</i>		24b. REGISTRAR'S SIGNATURE <i>Alv. eaduck</i>					



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07099

7106

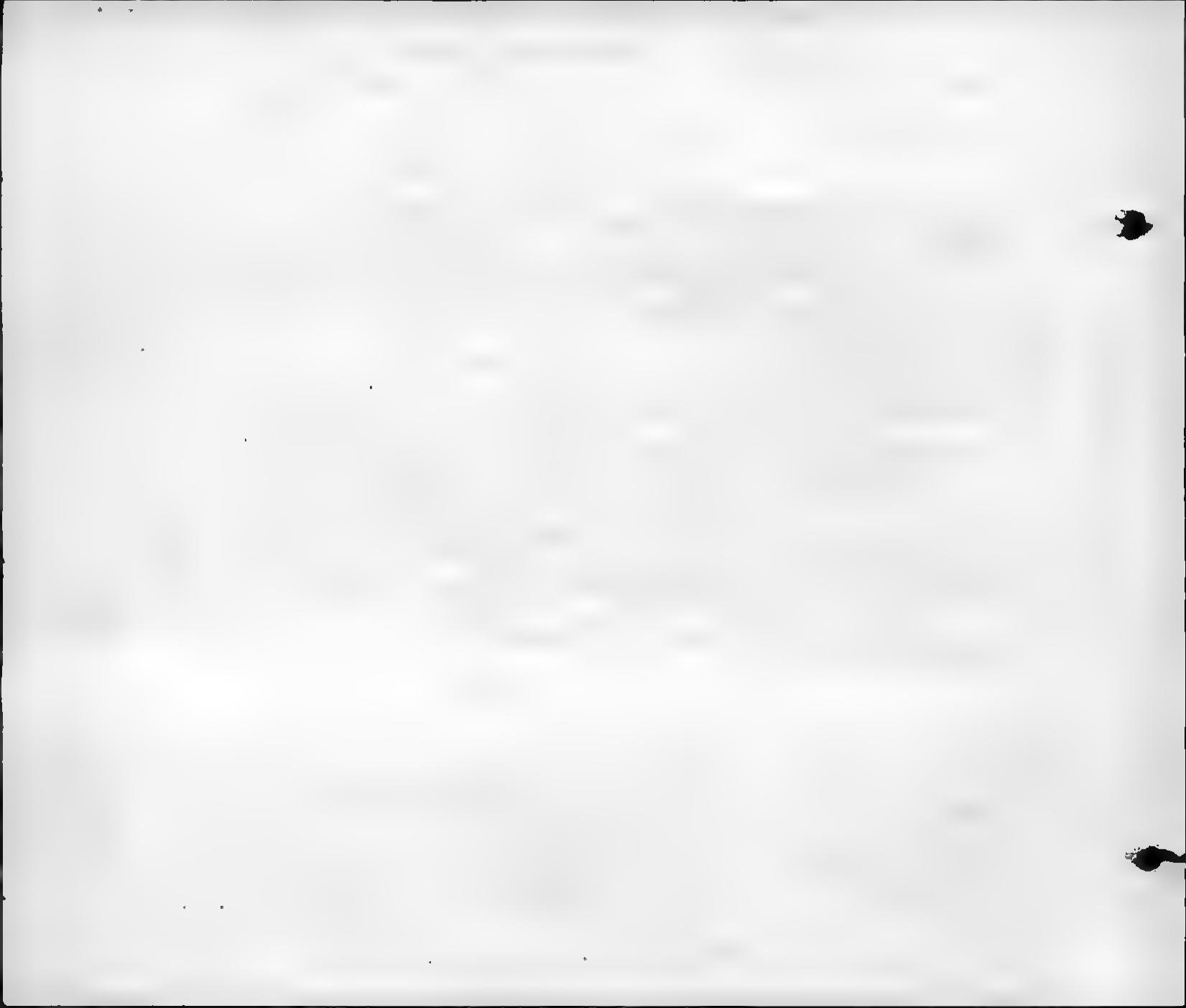
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN lb 5 hours		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase X					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital				d. STREET ADDRESS 7113 46th Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Lucile		First	Middle	Last	4. DATE OF DEATH Jebb	Month	Day	Year	
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 19, 1905	9. AGE (in years last birthday) 52 yrs	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. IF UNDER 24 HRS Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME James D Ervin		14. MOTHER'S MAIDEN NAME Julia K. Weeks							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. no		17. INFORMANT Hospital Record		Address Bethesda Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Congestive Heart Failure		INTERVAL BETWEEN ONSET AND DEATH 24 hours					
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		(b) Myocardial Insufficiency		24 hours					
(c) Patent Ductus arteriosus				life					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)		Pulmonary Fibrosis etiology indeterminate (Myocytic)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING LT OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Washington D. C.		(County)	(State)
21. I certify that I attended the deceased from June 1, 1958, to June 2, 1958, that I last saw the deceased alive on June 2, 1958, and that death occurred at 11:30 A.M. from the causes and on the date stated above.				ADDRESS (Street, city or town, state)					DATE SIGNED 6-2-58
ACTUAL SIGNATURE <i>Stewart Clapp</i>		M.D.		3921 Ingberman St.					
PHYSICIAN'S NAME (Type) Stewart Clapp				Wash 15 D.C.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/4/58		22c. NAME OF CEMETERY OR CREMATORIUM Mt Olivet Cemetery		22d. LOCATION (City, town, or county) Washington D. C.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		ADDRESS Hyattsville Md.		24a. REC'D BY REGISTRAR DATE JUN 5 '58		24b. REGISTRAR'S SIGNATURE Oliver			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07100

7107

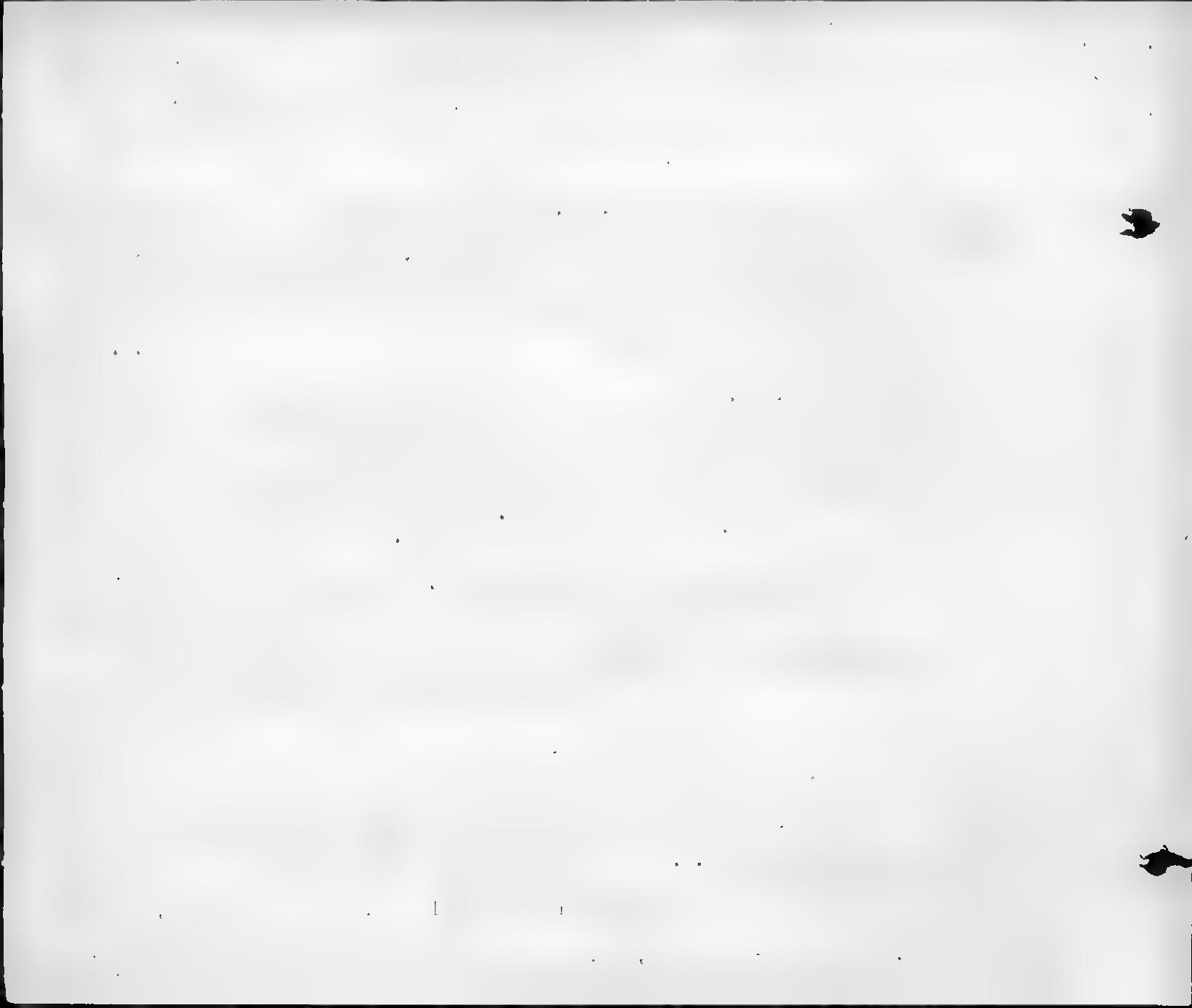
CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH o COUNTY Montgomery		MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) o STATE Virginia		b. COUNTY Henrico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 61 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Richmond			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS 5510 Danley Lane		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print)	First Richard	Middle Guy	Last Wells, Jr.	4 DATE OF DEATH June 3, 1958	Month June	Day 3	Year 1958
S SEX Male	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8 DATE OF BIRTH November 4, 1955	9 AGE (In years lost birthday) 2 yrs	10 IF UNDER 1 YEAR Months	11 IF UNDER 24 HRS Days	12 IF UNDER 24 HRS Hours
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b KIND OF BUSINESS OR INDUSTRY None		11 BIRTHPLACE (State or foreign country) Virginia		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Richard Guy Wells, Sr.		14 MOTHER'S MAIDEN NAME Gladys Davis					
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) No		16. SOCIAL SECURITY NO. None		17 INFORMANT The Medical Record		Address The Clinical Center, Bethesda 14, Maryland	
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Obstruction secondary to edema of larynx and epiglottis. DUE TO 2043 Conditions if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Dichloromethotrexate toxicity. DUE TO (c) Acute lymphocytic leukemia. PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f (City or town) The Clinical Center National Institutes of Health Bethesda 14, Maryland		(County)	(State)
21. I certify that I attended the deceased from April 3, 1958, to June 3, 1958, that I last saw the deceased alive on June 3, 1958, and that death occurred at 3:40 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) ACTUAL SIGNATURE ROGER LESTER, M.D. PHYSICIAN'S NAME (Type) ROGER LESTER, M.D. DATE SIGNED 6/4/58							
22a BURIAL CREMATION, REMOVAL (specify) Burial		22b DATE THEREOF 6/5/58		22c NAME OF CEMETERY OR CREMATORIAL Westhampton Memorial		22d LOCATION (City, town, or county) Chesterfield County, Virginia	
23 FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Md.				24a REC'D BY REGISTRAR JUN 6 1958 24b REGISTRAR'S SIGNATURE Overled / DATE			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item No.

7108

CERTIFICATE OF DEATH

Reg. Dist. No.

07101

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <i>Maryland</i>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Towson</i>		c. LENGTH OF STAY IN 1b <i>14 days</i>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Tuberculosis</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <i>9601-Bustich Ave.</i>				
3. NAME OF DECEASED (Type or print)	First <i>Wallace</i>	Middle <i>E</i>	Last <i>Westworth</i>			
4. DATE OF DEATH	Month <i>June</i>	Day <i>22</i>	Year <i>1958</i>			
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>July 29, 1894</i>			
9. AGE (in years less birthday) <i>63 yrs.</i>	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <i>1</i>	Days <i>5</i>	Hours <i>11</i>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Safety engineer</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>Engineer</i>	11. BIRTHPLACE (State or foreign country) <i>Mass.</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
13. FATHER'S Maiden Name <i>Longino</i>	14. MOTHER'S Maiden Name <i>Elise Grace Keith</i>	Address				
15. WAS EVER ENLISTED IN U. S. ARMED FORCES? (Yes or no or unknown) <i>Yes</i>	16. SOCIAL SECURITY NO. <i>152-07-1323</i>	17. INFORMANT <i>Mrs. Carolyn H. Westworth (Name)</i>	18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>442x</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. <i>Cerebral infarction, left cerebral</i> (b) DUE TO <i>Cerebral arteriosclerosis</i> (c) <i>Hypertensive Cardiovascular disease</i>	INTERVAL BETWEEN ONSET AND DEATH <i>1 Day</i>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Confused Hypertension Bronchopneumonia, Cirrhosis of liver</i>				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>Aug 19 1958</i>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>None</i>	20f. (City or town) <i>Baltimore</i>	(County) <i>Baltimore</i>	(State) <i>Md.</i>
21. I certify that I attended the deceased from <i>August 1958</i> to <i>June 22, 1958</i> , that I last saw the deceased alive on <i>June 22, 1958</i> , and that death occurred at <i>7:30 AM</i> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>429 Pershing Drive Silver Spring Md 20910</i>						
ACTUAL SIGNATURE <i>Seruch T. Kimble</i>	DATE SIGNED <i>6-22-58</i>					
PHYSICIAN'S NAME (Type) <i>SERUCH T. KIMBLE</i>						
22a. BURIAL, CREMATION, Cremation Facility <input type="checkbox"/>	22b. DATE THEREOF <i>6/23/58</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>FT. LINCOLN CREMATORIUM</i>	22d. LOCATION (City, town, or county) <i>PRINCE GEORGE COUNTY, MD.</i>			
23. FUNERAL DIRECTOR'S SIGNATURE <i>Warren E. Humphrey</i>	ADDRESS <i>SILVER SPRING, MD.</i>	24a. REC'D BY REGISTRAR <i>JUN 24 1958</i>	24b. REGISTRAR'S SIGNATURE <i>Alfred J. Smith</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4, may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07102

6966

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY

Montgomery

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Rockville

c. LENGTH OF STAY IN lb

3 1/2 yrs

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

1214 Edmonston Drive

3. NAME OF
DECEASED
(Type or print)

ISAAC

Middle

Last
WEST4. DATE OF
DEATHMonth
June
Day
13
Year
1958

5. SEX

Male

6. COLOR OR RACE

White

7. MARRIED NEVER MARRIED WIDOWED DIVORCED

8. DATE OF BIRTH

1/15/1879

9. AGE (In years
less birthday)
79 yrs.

IF UNDER 1 YEAR IF UNDER 24 HRS.

Months
4Days
28Hours
12Min.
00

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Laborer-retired

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Deleware

12. CITIZEN OF WHAT COUNTRY?

US

13. FATHER'S NAME

Joseph P. West

14. MOTHER'S MAIDEN NAME

Sarah W. Mitchell

Address

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

Hilda Werner same as 2 daughter

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

420.0

DUE TO

Conditions, if any, which
gave rise to immediate
cause (a), stating the under-
lying cause lost.

Arterios clerosis heart disease

INTERVAL BETWEEN
ONSET AND DEATH
10 yrs.

(b)

DUE TO

Generalized Arteriosclerosis

20 yrs.

(c)

MEDICAL CERTIFICATION

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED?

YES NO 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour o. m. 19
p. m.20d. INJURY OCCURRED
White Not white
at work at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I attended the deceased from 12-22, 1952, to 6-13, 1958 that I last saw the deceased alive on 5-26, 1958, and that death occurred at 4:00 A.M. from the causes and on the date stated above.

ADDRESS (Street, city or town, state)

DATE SIGNED

ACTUAL
SIGNATURE

W. G. Hall

M.D.

615 N. Montgomery Ave. Rockville Md 673-8

PHYSICIAN'S
NAME (Type)

W. G. Hall

615 W. Montgomery Ave. Rockville Md

22a. BURIAL, CREMATION,
REMOVAL (Specify)

Bur-Transit 6/13/58

22b. DATE THEREOF

22c. NAME OF CEMETERY OR CREMATORIUM

Red Mens Cemetery

22d. LOCATION (City, town, or county)

Bagsboro, Deleware

(State)

23. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

Robert A. Pumphrey Bethesda, Maryland

24a. REC'D BY REGISTRAR

DATE JUN 16 '58

24b. REGISTRAR'S SIGNATURE

A. Pumphrey

第二步：在新規則中，點擊「新增規則」，進入規則編輯頁面。

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07103

CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Md</i>		b. COUNTY <i>Mont</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Wheaton</i>		c. LENGTH OF STAY IN lb <i>4 yrs</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rockville</i> , Wheaton					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>2907 Weisman</i>		d. STREET ADDRESS <i>2907 Weisman</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <i>Mattie</i>		First	Middle <i>A</i>	Last <i>Whitman</i>	4. DATE OF DEATH <i>June 28 1958</i>	Month <i>June</i>	Day <i>28</i>	Year <i>1958</i>	
5. SEX <i>F</i>		6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>April 23, 1865</i>	9. AGE (In years last birthday) <i>93</i>	10. IF UNDER 1 YEAR Months <i>9</i>	11. IF UNDER 24 HRS. Days <i>3</i>	12. IF UNDER 24 HRS. Hours <i>0</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>no</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>no</i>		11. BIRTHPLACE (State or foreign country) <i>New York State</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>			
13. FATHER'S NAME <i>Edward Dearborn</i>		14. MOTHER'S MAIDEN NAME <i>Nancy Georgia</i>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>none</i>		17. INFORMANT <i>Neil Whitman</i>		Address <i>2907 Weisman</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma lung</i>		DUE TO <i>163X</i>		INTERVAL BETWEEN ONSET AND DEATH <i>6 months</i>					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>None</i>		(b) DUE TO <i>pulmonary edema</i>							
(c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		none				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>none</i>							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>none</i>		20f. (City or town) <i>none</i>		(County) <i>none</i>	(State) <i>none</i>
21. I certify that I attended the deceased from <i>4/1/58</i> to <i>6/28/58</i> , 19 <i>58</i> , that I last saw the deceased alive on <i>6/27/58</i> , 19 <i>58</i> , and that death occurred at <i>11:15 AM</i> , from the causes and on the date stated above.				ADDRESS (Street, city or town, state) <i>12026 Georgia</i>		DATE SIGNED <i>6/28/58</i>			
ACTUAL SIGNATURE <i>Patrick C. Jameson</i>		PHYSICIAN'S NAME (Type) <i>Patrick C. Jameson</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>6/30/58</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>Ft. Lincoln Cemetery</i>		22d. LOCATION (City, town, or county) <i>Prince Georges Co. Md.</i>		(State) <i>none</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>The S. H. Hines Company-Washington, D.C.</i>		ADDRESS <i>1000 Connecticut Ave. N.W. Washington, D.C.</i>		24a. REC'D BY REGISTRAR <i>Alt. Deuch</i>		24b. REGISTRAR'S SIGNATURE <i>Alt. Deuch</i>			
				DATE JUN 30 '58					

CERTIFICATE OF DEATH

1992

1992

1